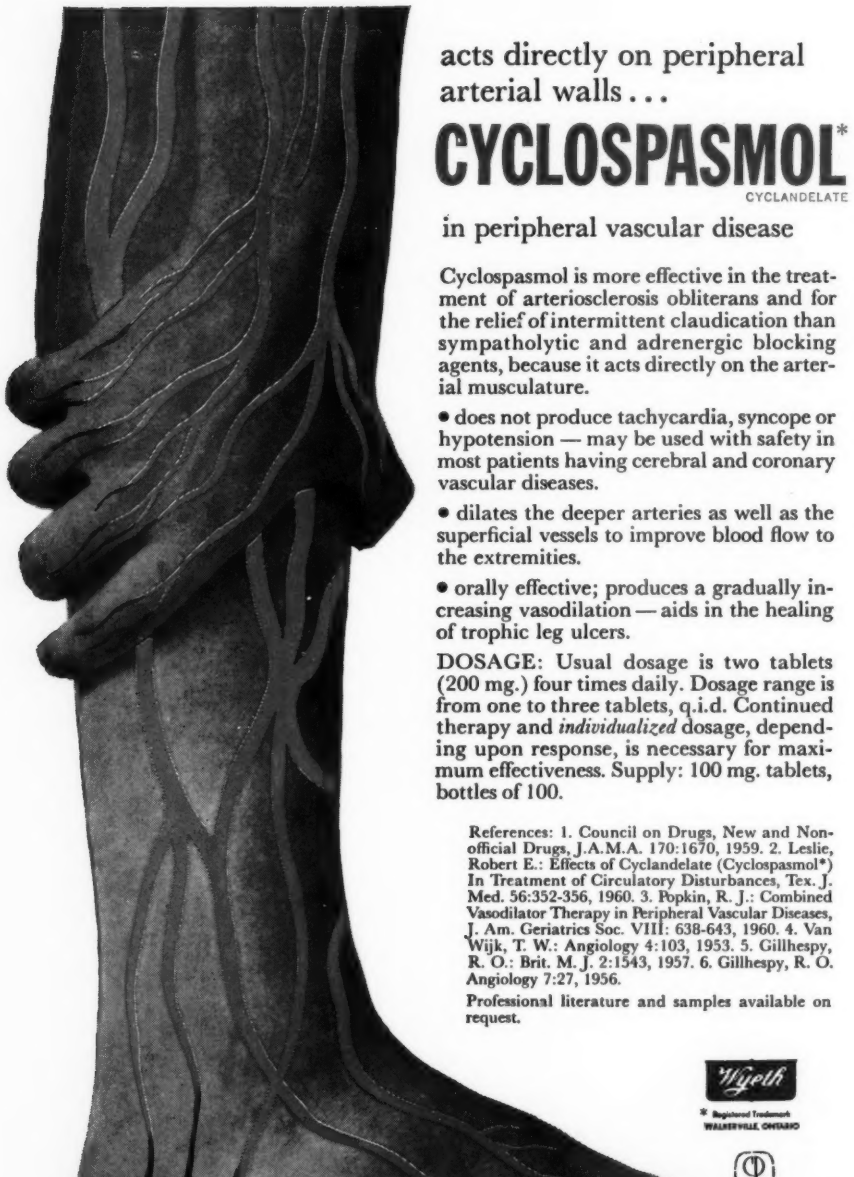
Manitoba Medical Review

Vol. 41 **No. 6**

June - July, 1961

Authorized as Second Class Mail, Post Office Department, Ottawa.

Official Publication of the MANITOBA MEDICAL ASSOCIATION Winnipeg Canada



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References: 1. Council on Drugs, New and Nonofficial Drugs, J.A.M.A. 170:1670, 1959. 2. Leslie, Robert E.: Effects of Cyclandelate (Cyclospasmol*) In Treatment of Circulatory Disturbances, Tex. J. Med. 56:352-356, 1960. 3. Popkin, R. J.: Combined Vasodilator Therapy in Peripheral Vascular Diseases, J. Am. Geriatrics Soc. VIII: 638-643, 1960. 4. Van Wijk, T. W.: Angiology 4:103, 1953. 5. Gillhespy, R. O.: Brit. M. J. 2:1543, 1957. 6. Gillhespy, R. O. Angiology 7:27, 1956.

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The Manitoba Medical Review

Vol. 41 JUNE - JULY, 1961 No. 6

Surgery

Acute Surgical Disease of the Abdomen Complicating Pregnancy

R. A. Macbeth, M.D., F.R.C.S.(C)
Professor of Surgery, University of Alberta

A 23 year old girl in the eighth month of her third pregnancy reports to the emergency ward at 8 o'clock in the morning complaining of moderately severe abdominal pain. Her previous pregnancies have been uneventful and her past history non contributory, in fact, she has always enjoyed good health. Review of the chart, in retrospect, reveals a rather cursory initial history and examination as a result of which no definitive diagnosis is reached. In this history one recognizes an unwritten but implied belief that a pregnant woman has some mysterious right to abdominal pain and vomiting which defies medical explanation. Eight hours later the patient is complaining of severe pain and examination reveals an elevated pulse rate and marked abdominal tenderness. Concern for her welfare is now apparent from the frequent progress notes and from the consultant's report that a diagnosis of abruptio placenta must be considered. A further delay of six hours follows during which emergency blood and x-ray examinations are obtained. During this interval the pulse rate rises to 120 per minute, the temperature to 102° F. and the abdomen becomes slightly distended with generalized rigidity, tenderness, rebound tenderness and absent bowel sounds. At laparotomy two hours later the abdomen is reported to be "full of pus" and the gangrenous appendix to have perforated at its base.

While such a case may be a relatively uncommon obstetrical experience, it is nonetheless a true one and doubtless accounts for the healthy respect with which the medical profession views acute surgical disease of the abdomen complicating pregnancy.

The present review began as a ten year survey of acute surgical disease of the abdomen during pregnancy in the four active treatment hospitals in the city of Edmonton. Unfortunately the coding of such cases had not been carried out in all hospitals throughout this entire period. The cases therefore have been drawn from only twenty-three cumulative hospital years which represent 59,758 confinements.

Acute Appendicitis

Acute appendicitis was the commonest extragenital cause of an acute surgical abdomen developing during pregnancy (Table No. 1). In this series of 98 patients with surgical disease of the abdomen, almost all of whom underwent operation, 50 of the operative procedures were carried out with a preoperative diagnosis of acute appendicitis.

Table No. 1
Extra-Genital Acute Surgical Disease of the Abdomen During Pregnancy
(98 Cases)

1) Appendicitis (Clinical Diagnosis)	50
2) Cholecystitis	20
3) Hernia	7
4) Bowel Obstruction	6
5) Pancreatitis	4
6) Ureteric Calculi	4
7) Acute Malignancy	2
8) Peptic Ulcer	2
9) Ulcerative Colitis	1
10) Acquired Hypertropic Pyloric Stenosis	1
11) Perforation or the Ileum	1

The analysis of these cases as to the final pathological diagnosis is of considerable interest. (Table No. 2). In 30 cases acute suppurative, ulcerative or gangrenous appendicitis was present, and in five of these frank perforation had occurred with generalized peritonitis which cultured Escherichia coli. In 11 cases, the appendix must be looked upon as being innocent as the cause of the abdominal pain, the pathological report being normal in nine and obliterative fibrosis in two.

Table No. 2
Appendectomy During Pregnancy
Pathological Diagnosis
(50 Cases)

Acute Suppurative or Gangrenous Appendicitis	30
a) Without Perforation	25
(b) With Perforation	5
Subacute Appendicitis	5
Acute or Subacute Periappendicitis	4
Normal	11
a) Normal	9
b) Obliterative Fibrosis	2

The incidence of acute appendicitis complicating pregnancy has been given as 1 in 1,200 cases by Philpott[13] on a basis of 7,147 obstetrical cases studied at the Royal Victoria Hospital in Montreal. Hamlin, Bartlett and Smith[5] reported an incidence of 1:2300 cases based on their observations on 92,772 deliveries at the Boston Lying-in Hospital. The incidence in the present series is 1:1992.

The average age of this group of patients with acute appendicitis was 22.4 years and their parity is illustrated in Figure No. 1. It is of interest to note that 70% of these cases occurred during the first two pregnancies.

Diagnosis

The diagnosis of acute appendicitis occurring during the first and second trimester of pregnancy appeared to offer no great difficulty in this series. The typical story of vague periumbilical or epigastric pain, later increasing in intensity and localizing in the right lower quadrant and associated with anorexia, nausea and often vomiting appears on the charts with monotonous regularity. The physical findings too were not dissimilar from those

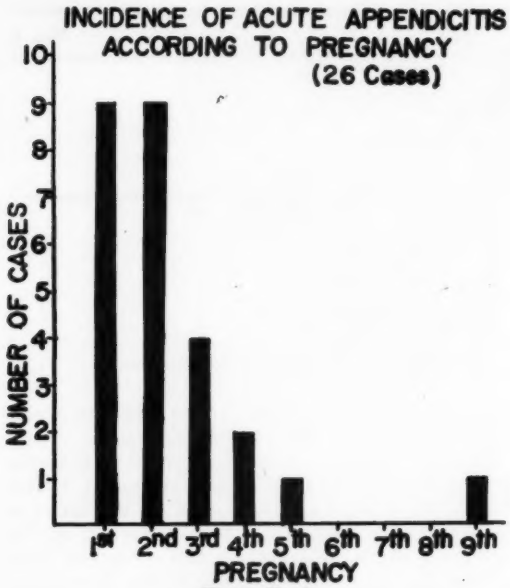

Figure No. 1

observed in the non pregnant state. Right lower quadrant tenderness was constant and almost invariably associated with rebound tenderness. Rovsing's sign was frequently recorded as being positive. It is said[5] that muscle guarding is minimal or absent in these cases because of the stretching of the abdominal wall that accompanies pregnancy. In the eleven charts in this series in which this finding was specifically recorded it was minimal or absent in five and moderate to marked in six.

While the diagnosis of acute appendicitis was invariably made during the course of the initial hospital examination when this disease occurred during the first two trimesters this was not the case in the last trimester of pregnancy. It is usually stated that acute appendicitis occurs most frequently in the first six months of gestation[7, 14], but in this series there was little indication of such a predilection (Table No. 3). One feature of acute appendicitis occurring in the last trimester is, however, obvious, namely, the frequency with which it tends to progress to perforation and generalized peritonitis. There were eight cases of acute appendicitis in the third trimester of which five had perforated and, in this series at least, all cases of perforated appendicitis occurred in the last trimester. A possible reason for this is apparent when one analyses the charts, for while the average

Table No. 3
Appendectomy During Pregnancy
Onset of Disease

	First Trimester	Second Trimester	Third Trimester
Acute Appendicitis:			
Unperforated	9	13	3
Perforated			5
Subacute Appendicitis	2	2	1
Periappendicitis	2	1	1
Normal	5	5	1
Total	18	21	11

interval between the onset of symptoms and operation was 20.6 hours in the unperforated cases, it was invariably over 48 hours in the cases with perforation. It would be grossly unfair to imply, however, that this delay was invariably due to procrastination on the part of the attending physician for in three out of the five cases the patient presumably misinterpreted the symptoms as being a normal accompaniment of late pregnancy and reported only when peritonitis was established. The difficulty that the physician may encounter in establishing a diagnosis of appendicitis close to term is illustrated by the case from this series that was used to introduce this presentation.

The white blood cell count and differential count are said to be of little help in the diagnosis of appendicitis in pregnancy because of the physiological leucocytosis that occurs during the latter[8]. While we would agree that a white blood cell count is seldom necessary in order to establish a diagnosis of appendicitis in any patient, there was a definite trend towards higher counts in the patients with acute appendicitis as compared with the "normal" controls in this series. The average count in twenty cases of acute appendicitis in which it was recorded was 16,500 with an average of 87% polymorphonuclear leucocytes. The average count in the eleven "normal" cases was 12,800 with an average of 80% polymorphonuclear leucocytes. In none of the "normal" cases did the count exceed 16,500 while counts in seven of the acute appendicitis cases exceeded this figure. We do not feel, however, that the white blood cell count is a necessary or even a particularly useful aid to the diagnosis of appendicitis in pregnancy.

Treatment

There is general agreement[4, 5, 9, 14] that signs and symptoms suggestive of acute appendicitis make early exploration mandatory in the pregnant female. Many patho-physiological changes inherent in the pregnant state have been recorded as favouring a more rapidly progressive and fulminating course for intraabdominal inflammatory disease associated with pregnancy[4, 14]. The mortality and morbidity of acute appendicitis during pregnancy is that of procrastination and delay.

In this series the McBurney incision was favoured and was used in half of the 50 cases. We personally favour this incision, particularly where the diagnosis is reasonably assured. The operative notes often indicated that "the incision was made at a slightly higher level than normal because of the complicating pregnancy" but the anatomical position of the appendix was not recorded in sufficient detail to confirm the study of Baer, Reis and Arens[1] that the appendix is displaced upwards and laterally and undergoes a counter clock rotation with the progress of pregnancy.

Prognosis

There was no maternal mortality in this series although the increased morbidity of appendiceal

Table No. 4
Appendectomy During Pregnancy
Summary of Foetal Loss

	First Trimester No.	First Trimester Aborted	Second Trimester No.	Second Trimester Aborted	Third Trimester No.	Third Trimester Premature Labour	Third Trimester Foetal Loss
Acute Appendicitis:							
Unperforated	9	2	13	1	3	—	—
Perforated	—	—	—	—	5	3	1
Subacute Appendicitis	2	1	2	—	1	—	—
Periappendicitis	2	—	1	—	1	1	—
Normal	5	1	5	—	1	—	—
Total	18	4	21	1	11	4	1

perforation is indicated by the average hospital stay of 14.7 days for this group as compared with an average of 6.2 days for the cases of acute unperforated appendicitis.

The foetal loss in the entire series is summarized in Table 4. The two patients with acute unperforated appendicitis who aborted in the first trimester did so on the 12th and 14th postoperative days, after they had been discharged. Neither had aborted during previous pregnancies. The single case that aborted in the second trimester did so on the 6th postoperative day and had spontaneously aborted two of three previous pregnancies.

Three of the five cases of acute perforated appendicitis went into premature labour but the foetus was salvaged in two who had reached the seventh and eighth month of gestation. In the other case, at seven months gestation foetal loss occurred.

Foetal loss also occurred in two other cases undergoing appendectomy in the first trimester. In the "normal appendix" case the record is interesting. This 19 year old primipara was operated on at six weeks gestation for severe right lower quadrant pain of two and a half days duration with typical physical findings of a right lower quadrant inflammatory process. At operation the appendix was normal, but the right ovary contained a cyst "the size of a tangerine." The patient was known to be pregnant and the possibility of a cystic corpus luteum was entertained by the competent gynaecologist in attendance. However he considered it to be "most certainly" a follicular cyst and it was removed. The pathological report was luteal cyst of the ovary and the patient began to have lower abdominal cramps the day after surgery and passed a complete sac three days later.

In the single case of acute periappendicitis occurring at eight months gestation operation precipitated labour but a viable foetus was obtained.

Cholecystic Disease

It was quite impossible from the material available for this study to determine the incidence of cholecystic disease occurring during pregnancy. Many, if not most, cases so diagnosed with or without radiological confirmation of disease were not coded in a manner which made them consistently accessible for analysis if conservative management was the only form of therapy instituted. It is generally agreed throughout the literature[5, 14] that a conservative approach to acute cholecystitis occurring during pregnancy is desirable, and that surgery should be reserved for those cases failing to respond to such a regime or cases which manifest complications such as perforation, empyema, common bile duct obstruction or concomitant pancreatitis. In chronic recurrent cholecystitis interval post partum cholecystectomy is favoured.

The diagnosis of cholecystitic disease occurring during pregnancy appears to have no special features apart from those commonly seen in the non pregnant female.

Insofar as surgery directed at the biliary tract during pregnancy is concerned Stone and Folsome[14] make a strong plea for conservatism on the basis of

1. The technical difficulties of biliary surgery in the presence of a gravid uterus.
2. The excellence of the prognosis for subsidence of the acute attack with conservative management.
3. The high incidence of termination of pregnancy associated with the combination of intraabdominal suppuration and biliary tract surgery.

In view of the widespread acceptance of the philosophy of conservatism in this condition we were somewhat surprised to find that in twenty cases of the present series surgery was carried out for inflammatory disease of the gallbladder during pregnancy. The patients were older than the group undergoing appendectomy, the average age being 30.25 years. The relation to parity is also interesting and is compared with that of the group undergoing appendectomy in Figure 2.

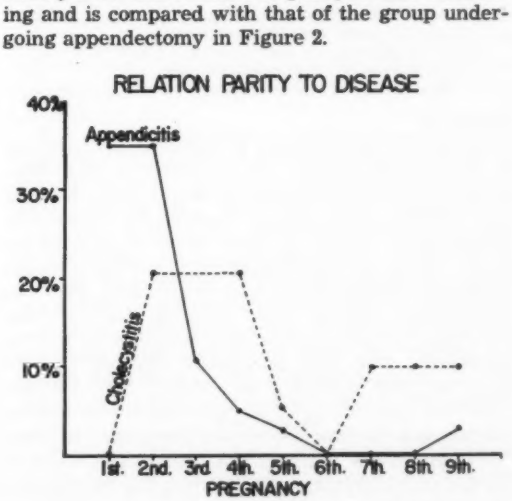

Figure No. 2

Indications for Operation

The indications for surgery in this series appear to be somewhat broader than those in the literature and are summarized in Table 5. It is probable that the number of biliary tract operations in this series does not accurately reflect normal incidence relative to the number of deliveries in these same hospitals over the same period of time, for only eight of the twenty patients were from Edmonton and would normally be confined in a hospital in this city.

Table No. 5
Cholecystectomy During Pregnancy
(20 Cases)
Average Age: 30.25 Years
Indications for Operation

1) Increasing Recurrences; Moderately Acute on Admission	10
2) Increasing Recurrences; Cold on Admission	6
3) Moderately Acute	2
4) Acute	2

The assessment of the acuteness of the disease as recorded in Table 5 is a clinical assessment. Pathologically sixteen cases were classified as chronic cholecystitis, one as subacute cholecystitis, one as acute cholecystitis and all were associated with cholelithiasis. In one case a normal gallbladder without stones was removed and in the final case cholecystostomy only was carried out and no tissue was available for study. Two cases had slight jaundice on admission to hospital.

Treatment

The operative procedure carried out in these twenty cases is summarized in Table 6. The magnitude of many of these procedures is of interest in connection with the prognosis for foetal survival in the group.

Table No. 6
Biliary Tract Operations During Pregnancy Procedure

Cholecystostomy	1
Cholecystectomy	7
Cholecystectomy and Appendectomy	6
Cholecystectomy and Exploration Common Duct	5
Cholecystectomy, Appendectomy and Exploration Common Duct	1

Prognosis

In this group of twenty patients one remains lost to follow up. There was no maternal mortality. Sixteen patients continued on to full term delivery of a viable healthy child. Foetal loss occurred in three cases. In one of these latter, a 21 year old multipara in the third month of gestation, abortion occurred on the day of cholecystectomy. Previous pregnancies had all gone to term. In the other two cases in which foetal loss occurred both were multipara who had previously aborted on one occasion and following the biliary tract surgery abortion occurred after an interval of two months in one and of three months in the other. In these two cases there is, therefore, reasonable doubt as to the causal relationship between the surgery and the foetal loss.

Intestinal Obstruction

Intestinal obstruction is fortunately a rare complication of pregnancy[2, 6, 10, 12] for it carries a grave prognosis. Hanson[6] in 1941 stated that among the cases reported in the English literature there was a maternal mortality of 31.25% and a foetal mortality of 57%. More recent publications would suggest that this gloomy prognosis has been much improved in the last twenty years but no extensive recent review has come to hand.

Statistics for the province of Alberta gathered by the Maternal Mortality Committee of the Alberta Division of the Canadian Medical Association record 186 maternal deaths in 327,809 confinements during the ten year period 1950 to 1959. Deaths due to extragenital acute surgical disease of the abdomen accounted for four of the 186 maternal deaths, and of these three were due to small bowel obstruction. The one remaining maternal death was a case of perforated appendicitis with peritonitis. None of these maternal deaths accurred in the series presently reported.

Diagnosis

The diagnosis of intestinal obstruction occurring during pregnancy appears to constitute the major hazard in the successful management of the patient. Colicky abdominal pain, abdominal distention, vomiting and constipation are complaints common to both diseases, and, since intestinal obstruction commonly occurs in the latter part of gestation, it is not surprising that these symptoms are usually initially dismissed as indicating the onset of early labour. This tetrad demands careful consideration at any stage in pregnancy. A past history of an intraabdominal surgical procedure should increase one's suspicion, for approximately one half of the cases of intestinal obstruction are due to adhesive bands (Table 7)[3]. Suspicion once aroused should

Table No. 7
Intestinal Obstruction During Pregnancy
(6 Cases)
Average Age: 30 Years
Pregnancy: First to Seventh
Gestation: 4 to 6½ Months: Average 5.6 Months
Etiology

1) Adhesive Bands	3
2) Small Bowel Intussusception	1
3) Pregnancy Ileus	1
4) Abdominal Pregnancy	1

proceed to a careful interrogation of the patient with regard to the rapidity with which distention developed, the nature of the vomitus and the occurrence of passage of flatus. Examination of the abdomen must be painstaking and detailed with special attention to the presence of high pitched bowel sounds and signs of peritoneal irritation. Where the diagnosis is in doubt reassessment at frequent intervals is essential. The relation of the cramping pain to peristaltic rushes on the one hand or to palpable uterine contractions on the other may assist in this difficult differentiation. Plain films of the abdomen, supine and erect, will prove to be the most useful laboratory aid to diagnosis.

Treatment

The management of intestinal obstruction in pregnancy in no way differs from that recommended in the non pregnant patient. The frequency with which resection of non viable bowel is found necessary and the difficulty encountered in the pre-operative separation of simple from strangulating obstruction in the pregnant patient does, however, necessitate a more aggressive surgical approach than in the non gravid individual.

Prognosis

In this series there was no maternal mortality. Four of the six patients went to full term and delivered a normal child in spite of the fact that in two cases gangrenous bowel required resection at the time of laparotomy. The case of pregnancy ileus[10] underwent two operations within a week of admission, subsequently contracted a wound infection and went into premature labour three weeks after her second operation to deliver a three pound four ounce viable foetus at seven months gestation. The only foetal loss occurred in the case of abdominal pregnancy in which the foetus was removed at laparotomy during the fifth month of gestation. This was the only case in this series in which conservative measures proved effective in controlling the obstruction.

Acute Pancreatitis

The incidence of acute pancreatitis complicating pregnancy, as distinct from the puerperium, is recorded as 1: 5,798 pregnancies by Langmade and Edmundson[11] who presented six such cases and reviewed the 53 acceptable cases in the literature up to that date. In the present series there were four cases, an incidence of 1: 14,939 pregnancies.

It is apparent from a study of the four cases in this series that the triad of epigastric pain, nausea and vomiting, especially if associated with epigastric tenderness, occurring during pregnancy demands consideration of acute pancreatitis as the possible etiological factor. The diagnosis can be confirmed relatively simply in the early stages of the disease by demonstrating the presence of elevated serum amylase levels. A conservative regime similar to that recommended for acute pancreatitis in the non pregnant individual is the treatment of choice. The necessity of performing operative decompression of the biliary tract during pregnancy in two of the four cases in this series would suggest that conservative measures alone are frequently inadequate. There was no maternal mortality in this small group and it is surprising that the only foetal loss that occurred was the result of planned therapeutic interruption of pregnancy recommended because of the recurrent episodes of pancreatitis. All three cases permitted to go to term had subsequent definitive surgical procedures on the biliary tract and in both of those in which a significant interval occurred between delivery and the second procedure recurrent acute attacks occurred in the puerperium.

The remaining eighteen cases in this series are tabulated in Table 1 but time does not permit a discussion of the interesting features which some of these cases presented.

Summary and Conclusions

Acute appendicitis is the commonest extragenital cause of acute abdominal disease occurring during pregnancy. The tetrad of abdominal pain, anorexia, nausea and possibly vomiting in the pregnant female requires immediate, careful assessment in all trimesters if serious sequelae are to be avoided. The diagnosis, relatively simple in the first two trimesters, is progressively more difficult as term approaches, and procrastination at this time is fraught with the danger of perforation, maternal morbidity (or even mortality), premature labour and foetal loss. Abortion is more commonly associated with appendectomy in the first than in the second trimester, but a diagnosis of acute appendicitis is an indication for immediate laparotomy regardless of the stage of gestation, an indication more urgent in the pregnant than in the non pregnant state. It is often said that laparotomy and removal of a normal appendix carries no risk to either mother or child during pregnancy. This statement might be considered to be substantiated in this study as long as removal of the appendix is not accompanied by the removal of the corpus luteum during the first trimester.

Cholecystic disease occurring during pregnancy is usually considered to be ideally treated by conservative measures, and we would agree with this attitude. It would appear from this series, however, that surgery directed at the biliary tract does not carry with it as grave a prognosis with regard to maternal and foetal morbidity and mortality as the literature would suggest.

Intestinal obstruction tends to occur during the latter months of pregnancy and carries with it a grave prognosis. This would appear to be largely due to delay in diagnosis through confusion of the symptomatology with that of early labour. Surgical intervention is more urgently indicated in intestinal obstruction in the pregnant than in the non gravid patient.

Acute pancreatitis occurs during pregnancy with sufficient frequency that this diagnosis must be considered in any patient presenting with epigastric pain, nausea and vomiting. The treatment is primarily medical but biliary decompression may be necessary during pregnancy for control of the disease. Recurrent attacks in the postpartum period frequently necessitate further definitive surgery.

It is a privilege for me to acknowledge the assistance that I received from the doctors and record librarians in the city of Edmonton in connection with this study and record my appreciation.

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Psychiatry

The Story of Psychiatry in Manitoba

J. Matas, M.D.

Among the earliest inhabitants of Manitoba, the Cree and Objibwa Indians, the best publicized psychiatric reaction was labelled "Windigo." The disorder combines homicidal behaviour with cannibalistic fears and tendencies. It is named after an Ojibwa speaking demon with cannibalistic tendencies. He was thought to be the ghost of some person who had been obliged to eat human flesh to stay alive. The "Windigo" was believed to haunt the woods, especially in bitter weather, seeking victims, so that it might satisfy its endless hunger for human flesh. The explanation for the illness was the age old one of demoniac invasion. The treatment of this illness was complete banishment from the community by death[1]. With the Indians this was indeed a final disposal, because they were not great believers in the hereafter. The methods of treatment for the mentally ill by the later arrivals to Manitoba from Europe, also showed this tendency to use expulsion. However, the ejection was less permanent, behind stone walls and barred windows, rather than to the happy hunting grounds of the hereafter.

As late as 1900 an Indian near Battleford was sent to the penitentiary for life, for killing a female relative in the belief that being mentally ill, she might eat some member of the family[2].

Among the white settlers before 1871, there was no provision for the mentally ill. They were allowed to wander at will, but in 1871 the Dominion Government established the Manitoba Penitentiary at Lower Fort Garry. Until 1877 the mentally ill were confined along with the criminals in one of the stone buildings at the Fort. In 1877, the mentally ill were moved to the newly built Stony Mountain Penitentiary. Official government correspondence of the early 70's contains various terse statements to the effect that John Jones having been judged insane, was confined to the Stone Fort, as it was popularly known then, or occasionally, that he had been sent in custody to an institution in the East[3].

Until 1877 only the mentally ill who were considered really dangerous were confined. Female patients were segregated, but the men shared quarters with the convicts.

For practical rather than humanitarian reasons this arrangement was not considered entirely satisfactory to the authorities. On November 19th, 1879, for example, Undersecretary of State, Langevin, wrote to Alexander Morris, the 2nd Lieutenant-Governor of Manitoba, saying that it had been brought to the attention of the Federal Government, that mentally ill were being confined to the Lower Fort with criminals, and urging that he draw to the attention of his government the desirability of the two groups being separated. "Owing to the limited accommodation in that institution," he wrote, "very great inconvenience and annoyance is created, and lunatics interfered much with the discipline of the institution, some of them being very boisterous, requiring additional guards on duty." Almost as an afterthought, he adds: "this view as distinct from the impropriety of lunatics being confined in what is legally a penitentiary."[5]

Whatever the motive behind the move, an order-in-council was passed in 1879, requiring that all cases of mental illness in Manitoba and the North West Territories should be admitted and cared for in a portion of the building separate from the convicts.

Under the new regulations, families who had been reluctant to surrender afflicted relatives to the confines of a penitentiary now allowed them to enter the institution, and the number of mentally ill confined, increased rapidly. By 1883, it was recognized that further provision was needed for the confinement of the mentally ill. Accordingly, in 1884, the Provincial Government passed an act authorizing the building of an "asylum," to provide for their proper care. The spot chosen for the

"Lunatic Asylum," as it was called in the eighties, was at Selkirk, on the site of the present mental hospital. Dr. David Young was appointed first superintendent of the projected institution.

At approximately the same time, the Dominion Government, in 1884, notified the provincial authorities that the insane must be removed from penitentiaries without delay. As the Selkirk institution was not yet completed, accommodation for the mentally ill had to be found once again at Lower Fort Garry. Another building was prepared for their reception in addition to the original building, and in February 1885, 35 patients — 27 men and eight women — were transferred there from Stony Mountain.

The first building of the Selkirk asylum was completed in 1886 and Dr. Young assumed his duties as medical superintendent. As a young graduate from Queen's, Dr. Young came to Manitoba in 1871 and took up residence on the banks of the Red River where he established a practice near the Lower Fort. As head of the Selkirk institution—a position he held from 1886 to 1912, when he retired to private life — Dr. Young brought, in the words of Dr. Ross Mitchell, "professional skill, insight and kindliness into his treatment of the mentally afflicted."[5]

It soon became apparent that one institution was inadequate for the care and treatment of mentally ill persons from the entire province and the North West Territories. New settlers were pouring into the West, and to meet the increasing demand for additional space an institution was established at Brandon in 1892.

The building at Brandon had been constructed in 1891 as a reformatory for boys. Its first and last criminal inmate was a 9 year old boy, Billy Mulligan, who was sentenced to five years imprisonment for stealing a letter from Her Majesty's mails. The superintendent of the reformatory was Sir Clifford Sifton and the chief warder was one Archie Campbell. It cost the province $30,000 to run the institution as a reformatory for six months for the sole benefit of its one small prisoner. At the end of that time Billy Mulligan was moved elsewhere to serve out his time and in 1892 the building was converted into an asylum for the mentally ill[6].

Dr. Gordon Bell was the first superintendent of the Brandon institution, a post to which he was appointed following his graduation from the Manitoba Medical College in the class of 1890. Subsequent to his appointment as medical superintendent at the Brandon hospital, he took post graduate work in Vienna, and later, moved into other fields of medicine to make Manitoba medical history.

The First World War, as did the Second, provided an impetus for development in psychiatry in Manitoba as elsewhere. In 1918 the entire psychiatric service of the province was reorganized by the provincial government with the appointment of a general director as provincial psychiatrist. The man appointed first to this post was Dr. A. T. Mathers. Dr. Mathers did pioneering work in educating the doctors of the province in psychiatry, besides carrying the load of community psychiatry practically single handed. He was very interested in forensic psychiatry and was frequently called on as an expert witness.

In 1919 the Mental Diseases Act was passed. It provided for the changing of the name "asylum" to "Hospital for Mental Diseases." It also provided for admissions to mental hospitals to be carried out in the form we know today.

Also in 1919 the Winnipeg Psychopathic Hospital was established—the first in Canada to be associated with a general hospital. The Psychopathic Hospital was operated by the Provincial Government in agreement with the Winnipeg General Hospital Board. This institution was under the direction of Dr. Mathers and Dr. M. M. Musgrove.

A summary of events at the Brandon institution in the 20's and 30's indicates the general trend of developments and the achievements of this period. Dr. C. A. Barriger, superintendent in the 20's, established a training school for nurses and attendants, and a new program was inaugurated. A small laboratory was opened and the first dentist, non-resident, was appointed to give part time service.

In January, 1921, the Colony Building was opened, and in June of the same year, an occupational therapy department opened under the direction of two instructresses.

In 1923 the first graduation of nurses was held, and in 1925 a great stride was made with the opening of a Reception Hospital in which the departments of Hydrotherapy and Electrotherapy began to operate with improved equipment and increased efficiency.

In 1926 the first Mental Hygiene Clinic was established in Brandon city.

Open wards in mental hospitals are a much publicized development just now. It is interesting to learn that in 1931 the open ward system was established in the Reception Service and has been continued since. A women's Pavilion for chronic, disturbed women patients was opened in 1932, and x-ray apparatus added to the hospital equipment in 1933.

A comparison of the staff-patient ratio between the years 1918 and 1935 reveals the following gradual improvement: In 1918 the total staff at Brandon was 105 compared to 265 in 1935. The total number of patients increased from 713 in 1918, to 1,302 in 1935, showing an increase in the ratio of staff to patients from 1 staff for 4.6 patients. Comparing the same years, the number of physicians increased from 1 to 7, showing an increase in ratio of from 1 for 713 to 1 for 186. The number of nurses, both male and female, increased from 45 in 1918 to 181 in 1935, the ratio changing from 1 nurse for 15 patients to 1 nurse for 6 patients[7].

While these developments, as indicated in the summary of events at the Brandon institution were laudable, the overall situation was far from ideal. A 1929 report on hospitals and nurses' training schools in Manitoba, by the Health and Hospital Survey Committee of the Welfare Supervision Board of Manitoba, noted: "the very serious crowded condition in the chronic divisions in the hospitals at Selkirk and Brandon," and deplored "the use of ill-ventilated, overcrowded basement dormitories in both Brandon and Selkirk, and the lack of adequate toilet and bathing facilities."[8].

A survey conducted by the Welfare Supervision Board in 1928, showed that the Manitoba Psychopathic Hospital, serving the whole province, had 32 beds. Brandon, serving a 640,000 square mile area, had 1,093 beds and an average of 1,038 patients a day. Selkirk, serving a 300,000 square mile area of the East Section of the province, had 580 beds and had 513 patients a day[9].

In 1932, as an economy measure, the bed capacity at the psychopathic hospital was reduced from 32 to 24. This caused further overcrowding in the other hospitals and a curtailment of stay in hospital for some patients. Throughout the depression years, however, the Psychopathic Hospital managed to avoid a return to the early practice of confining the mentally ill in prisons. All "police" cases, which otherwise would have had to be housed in gaol, were kept at the hospital[10].

In 1933, the Mental Deficiency Act was proclaimed, and the Portage institution, after three years of preliminary work at the school under a medical administration determined by the Department of Health and Public Welfare, became the: "Manitoba School for Mentally Defective Persons." This Act can be cited as historic in Manitoba, for it heralded the beginning of a new endeavour in social service, namely, the care and training of the feeble minded in the province.

But even more than the other institutions, Portage suffered for many years from serious overcrowding and lack of sufficient funds to carry out a patient program. In his Activities Report for 1933, Superintendent H. S. Atkinson reported that deaths at the institution had increased somewhat in the last few years, the chief cause of death being tuberculosis. In 1934 he reported that overcrowding in the institution was 33 1/3% above normal. Since then, construction of new accommodation has made possible the segregation of patients with infectious diseases and led to the establishment of successful occupational and recreational programs.

In 1933 the total number of patients in the school was 391. By December 1956 this number had grown to 820[11].

In 1938 an investigation into conditions at the Selkirk institution was held. On March 9th, Dr. E. C. Barnes, Medical Superintendent of the hospital complained before the public accounts committee of the legislature, that lack of funds was responsible for the over-crowded conditions in the hospital. He denied that the institution was understaffed and pointed out that, with the exception of Prince Edward Island and Alberta, Manitoba had a better average of attendants per patient than any other province in Canada. He also stressed the need for a separate wing for the care of tubercular patients. This Public Accounts Committee also heard of nurses contracting tuberculosis, of unpalatable food and of a bitterly discontented staff.

Testifying about the food served in the institution, nurse Edna Wright complained that "evidence of the digestive activities of mice often appears in the food. Once a mouse's tail was found in a pudding and another time a mouse's skeleton appeared in the porridge."

Dr. Barnes added further complaints about the condition of the old buildings, saying that pots and pans which had to be spread about to take care of leaks in the roof on rainy days were sometimes used for more violent purposes by the patients[12].

As late as 1930, the "cage"—now a museum piece in Toronto — was still at the Brandon institution but hadn't been used for some years. This device, which was lowered over the bed, was intended to give the patient a sense of security, and at the same time to prevent him from harming other patients. The "bullpen" was still a commonly accepted form of exercise for male patients. Such antiquated measures were shortly abandoned[13].

Insulin shock was introduced at Selkirk in November 1936 by Dr. Edward Johnson where it was used experimentally on 100 patients. In October 1937 it was introduced at Brandon. Convulsive shock therapy in the form of Metrazol was introduced at Brandon in November 1937[14].

The war years created more problems for the mental institutions. Staff shortage, for example, led in turn to the curtailment of insulin shock therapy, although electro-shock treatments (introduced in 1942) were carried on as usual.

Psycho-surgery was introduced at Brandon in May, 1943, when Dr. Oliver Waugh performed the first leucotomy. Following two operations in 1943, 21 more were carried out in 1944[15].

In reviewing events of the forties, mention should be made of the Buck Report submitted in 1941, by a committee headed by Dr. Carl Buck on a study of Manitoba's health administration, made at the request of the Provincial Minister and Deputy Minister of Health and Welfare. The report contained four recommendations for improved care of the mentally ill. It recommended that:

1) an institution of approximately 250 beds for custodial care be established, probably at Portage la Prairie, to which senile cases from hospitals for mental diseases could be transferred.

2) that a unit for infirmary patients be established at Selkirk by re-arrangement, reconstruction or new construction with facilities for adequate segregation of tubercular patients.

3) that mental hygiene activities at the Psychopathic Hospital and the institution at Brandon, be increased substantially, and that specific appropriations be granted for mental hygiene.

4) and that, at the earliest possible moment, the Manitoba School for Mentally Defective Persons segregate its cases according to the degree of mental defectiveness, separating children from adults, and in the future, admitting children rather than adults[16].

"Hospitals in Manitoba," a report of a study by the Welfare Supervision Board, published in 1944, concurred with the recommendations of the Buck report. It noted evidence of over-crowding, and revealed that, as of 1944, the Brandon Hospital had 1,300 beds and served 1,514 patients a day; Portage had 407 beds and served 455 patients a day; Selkirk had 646 beds and served 866 patients a day.

Manitoba, however, was found to care for its mentally ill as well as, or better than the other provinces, and it was noted that the Brandon, Selkirk, and the Winnipeg institution, were on the approved list of the American College of Surgeons[17].

Up until World War II, most psychiatric activity in Manitoba could pretty well be chronicled by referring to the developments in state institutions. Since World War II, there has been an increasing tempo of psychiatric activity outside of the mental hospitals. The development of psychiatric wards in General Hospitals is one indication of this. The first such ward in this area was in Deer Lodge, the local Veterans' Hospital. Every large General Hospital in Winnipeg now has such a ward. Another indication of extra-mural psychiatric activity corresponding to the General Hospital development, is the increasing number of full-time psychiatrists in community practice. Before World War II there was none.

The practice of psychiatry is only recently reaching the level at which intensive and reconstructive psychotherapy is practised. Most psychotherapy is still supportive with a great deal of emphasis on physical treatments.

The current awakening of interest in hypnosis seen in the United States and England is becoming evident here among the medical profession. Some of the dentists have shown an interest in it for some years. Of course, this awakening of interest in hypnosis in the Western world has occurred largely in non-psychiatric medical practice, and will probably gain momentum in the near future.

Among these developments one must mention the expansion of special classes for retarded children promoted by the Association for Retarded Children of Manitoba. These are for children who are ineligible for public school training because of low I.Q. levels. Special classes for retarded children in the category of Moron have existed for many years in Winnipeg and a few other school districts, and have extended lately on a wide scale with grants in aid from the Provincial Department of Education. The Kinsmen school was opened in Winnipeg, in the spring of 1957, and has more than one hundred children enrolled.

Child Guidance, in the Winnipeg area was begun in the '30s and since then the school boards of St. James and West Kildonan have organized similar clinics. A major development which will soon likely come to fruition, is a building in the medical center, to house the Child Guidance Clinic for Greater Winnipeg, special placement classes for disturbed children, and also classes for children with severe physical handicaps. This arrangement would give these children ready access to the investigative and remedial services of the Children's Hospital.

In keeping with the world wide trend to look upon alcoholism not as a "badness" but a "madness," there has been greater community efforts to deal with this problem. These efforts are centered in the Alcoholism Foundation, whose function to date has been largely educational. However, in 1957, a building was acquired in which there are a few beds that can be used for rehabilitation purposes. Also, in keeping with this new outlook, patients suffering from acute alcoholism are admitted more readily to some General hospitals and to the Psychopathic Hospital.

In 1957 the department of the Attorney General appointed Dr. George Little, who served many years in the Provincial Hospital Services, to serve the correctional institutions and the Juvenile and Family Courts. Billy Mulligan stole his letter 67 years too soon.

In spite of all these extra-mural activities, in his review for 1956, Dr. Pincock reported that total admissions to mental hospitals in Manitoba had increased by 126% from 1946 to 1955. At the end of 1955 Manitoba had 3,547 patients under care in its four institutions, compared with 3,135 in 1946.

To meet its increased obligations in the field of mental health, Dr. Pincock announced that Manitoba had taken the following steps: increased the standard bed accommodation from 2,578 to 3,400, or 31.9%; increased its budget for maintenance and preventive measures from approximately two million to nearly four million dollars annually. He reports the ratio of staff to patient had increased from one staff member for 4.9 patients, to one staff member for every 3.4 patients[18].

It is since World War II that the mental hospital has shown the greatest change. The trend, begun in the thirties, of using the hospital as active treatment centres integrated into the community, is gaining increasing momentum. Open wards allow the patient to retain his contact with the community. Voluntary organizations, such as the one called "Share," (Selkirk Hospital Athletic, Recreational Entertainment), bring the community into

mental hospitals. This group consists of volunteers, mainly from Winnipeg, who regularly go out to Selkirk Hospital and look after many of the patients' needs. Probably the most important function performed is helping to remove the feeling of isolation from other human beings, that the patient has. The members feel that their function is to share themselves and their love. The use of the mental hospital as part of the university teaching program, is another step breaking down the former isolation.

Some of the changes in the mental hospitals over the years are indicated by comparing the admission and discharge figures from Selkirk Mental Hospital, in 1932, 1947 and 1957. 1932 was chosen, as it was still in the pre-insulin era; 1947 as a convenient immediate post-war year and prior to the era of tranquilizers.

The figures are:

1932: Admissions—Total 164 Discharges—40%
1947: Admissions—Total 181 Discharges—63%
1957: Admissions—Total 360 Discharges—72%

Over this period admission of patients suffering from General Paresis of the Insane has dropped from 5 - 10% of the total, to an insignificant number, indicating the efficacy of the improved methods of detecting and treating syphilis. There has been a tremendous increase in the percentage of patients admitted suffering from senile or arteriosclerotic psychosis. The percentage admission of the functional psychoses has remained fairly constant.

The discharge rate has increased in the manic depressive illness to some extent. However, there has been a very satisfactory increase in percentage of schizophrenic patients discharged. The rate of discharge in the functional psychoses now almost balances the admission rate. The main stationary group in hospital now, is the old age group[19].

Our legislators, both provincial and federal, took cognizance of the mental health problem and demonstrated their concern in a concrete way by mental health grants. These grants have aided and encouraged many of the developments of post war psychiatry. One of these was the establishment of a faculty of psychiatry, headed by Dr. G. Sisler, who is pushing forward an active undergraduate teaching program and an expanding post graduate one.

Since Manitoba was incorporated 88 years ago, the Indian spirit Manitou brooding over his domain, has seen revolutionary changes in the management of the mentally ill. At the beginning, a large part of the population killed their mentally ill, later they were ignored or put to gaol. Now, the wheel is beginning a complete turn. The perverse and criminal are again being grouped with the mentally sick, but now, not as a matter of convenience for the community, but because of a better recognition of what illness is.

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Medicine

Oral Agents in Diabetes Mellitus

J. P. Maclean, M.D. and A. W. Alvi, M.D.

Whether to use an oral agent in the management of his diabetic patients should be a problem to the practicing physician. He is cajoled by the pharmaceutical industry, pleaded with by his patients and buried under a mountain of published data. Is there a simple formula for deciding which patients should receive an oral agent, and if so, which one of those currently available should be used?

After using one of these drugs—chlorpropamide, a sulfonylurea compound on a group of patients for a period of nearly three years we have some impressions, but few firm conclusions. Early in the study we found, as others did, that the sulfonylurea drugs were of no value in controlling the juvenile or "brittle" diabetic. Chlorpropamide reduced the blood sugar level in 36 of 43 stable diabetics followed from four to ten months. These results were reported with what appears in retrospect, a somewhat foolish title: "Long Term Therapy with Chlorpropamide."[1]

On reviewing these same 36 "well controlled" subjects two years later we find the following:

1. Eight are dead.

a) Five maintained good control of blood sugar till death four, eight, ten, twelve, and 24 months after starting therapy. The drug was not responsible for the death of any.

b) Two gained excess weight during 11 and 19 months of therapy respectively. Despite normoglycemia they are considered failures because of the weight gain. Death occurred after chlorpropamide therapy was stopped.

c) One subject, only slightly hyperglycemic on diet alone was given chlorpropamide to test the effect on parasthesiae. Normoglycemia was obtained for the seven months on therapy, but no change in the neuropathy was noted. The patient died five months after stopping the chlorpropamide.

2. Three are lost to follow-up.

a) Two are in nursing homes on small doses of insulin. Normoglycemia was maintained for eight and ten months respectively. The reason for restarting insulin is not known.

b) One was normoglycemic on chlorpropamide for 14 months, discontinued the drug, became glycosuric and was lost to follow-up.

3. Eight have had the drug discontinued.

a) One subject developed chronic urticaria while on the drug for 20 months. Tolbutamide produced the same effect so insulin was restarted with a definite improvement in the skin condition.

b) Two subjects no longer require the drug and are controlled by diet alone. One of these lost 70 lbs. during the 24 months on the drug. The other remains overweight but medication was stopped after 12 months because of a severe hypoglycemic reaction possibly due to self overdosage.

c) Three subjects maintained good control for 21, 24 and 24 months with fairly abrupt loss of control without significant weight change. These three are now harder to control with insulin than before the study started.

d) Two who failed to lose weight became hyperglycemic after about six months. Both are on insulin and are still hyperglycemic.

4. Seventeen remain on therapy with adequate blood sugar control. The duration of therapy in these subjects varies from 28 - 34 months. Three discontinued the drug for a period during the study, but were restarted when glycosuria returned. Several have remained obese. Two have gained weight, an excess in one and worthwhile in the other.

The conclusion that 36 of 43 subjects with stable diabetes could be controlled better with chlorpropamide than with previous therapy should be changed to 19 of 32 subjects, including two who can now maintain reasonable blood sugar levels with diet alone. Those who have died, or been lost are excluded.

Discussion

Chlorpropamide, a sulfonylurea with a chloride radical replacing the methyl group of tolbutamide is more potent than tolbutamide because of a difference in metabolism and excretion. The blood level of either drug which causes hypoglycemia is the same[2]. As toxic reactions have been described with both drugs, the price of the daily requirements should be the determining factor in choosing which drug to prescribe. These drugs will not prevent ketosis in the juvenile diabetic. Bi-guanide tablets have been suggested for the juvenile or "brittle" diabetic. In our limited experience the therapeutic level and the toxic level are too close. As these patients require insulin as well, there appears to be little advantage in adding a further drug.

Overweight patients gained more weight when glycosuria was decreased. This is probably due to retention of calories which were previously lost in the urine. Moreover, we think the hypoglycemic effect of the drug may even stimulate the appetite.

Where polyuria, polydipsia or intertrigo were a problem, establishment of normoglycemia seemed worthwhile even though the patient did not lose weight. The development of hyperglycemia in three patients after two years of good control raises the problem of exhaustion of the Islets of Langerhans. This could pose a problem with other patients in time. We have not observed any progression or retardation of diabetic complications.

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Gynecology

Septic Abortion

J. Greene, M.D.

Definition

Greenhill defines septic abortion as occurring when the cavity of an aborting uterus becomes infected. Taussig states that abortion is the detachment or expulsion of the previable ovum—the lower limits of viability being 26-28 weeks of gestation. The diagnosis of the infected abortion is made when the patient's temperature is 100.4 or more on any two consecutive days, or at least 101 degrees F. on any single day.

While many factors may contribute to the development of abortion, whenever a significant degree of infection is present criminal interference should be strongly suspected. This may be due to the manipulations of a professional, a clumsy amateur, or the patient herself. On the other hand there is undoubtedly a certain group of patients undergoing spontaneous abortion who become infected coincidentally. The patient may be contaminated by douches, intercourse, tampons or other means. The doctor may introduce or spread infection by careless technique.

Pathogenesis

For the sake of simplicity, septic abortion may be divided into three main categories dependent on the extent of the disease process. In category 1, the patient's infection is confined to the endometrial cavity and its contents. In category 2, the infection is still confined to the pelvis, but has spread beyond the uterine cavity to the parametria, adnexa, and pelvic peritoneum. In category 3, the picture is that of generalized sepsis and its protean manifestations. It should be realized that such dogmatic staging cannot be completely accurate and that constant clinical evaluation is of prime importance.

Category 1 — The bacteria deposited or carried into the endometrial cavity soon invade retained products of conception as well as the endometrium (decidua), and a superficial part of the myometrium. Large numbers of leukocytes infiltrate the latter structures forming a defence barrier against the further spread of infection. Frequently there is necrosis, liquefaction and suppuration of the retained secundines, giving rise to foul vaginal discharge. Slight bleeding may occur, but the leukocytic infiltration seals off the superficial blood vessels so that frank hemorrhage is quite unusual. There is a low grade fever of 99-101 degrees, the pulse rate is only slightly elevated, and the patient does not appear to be acutely ill. On pelvic examination the uterus is boggy, somewhat enlarged and slightly tender.

Category 2 — The superficial barrier built up may not hold against the onslaught of the infectious process. This may be due to the great virulence of the organisms involved, insufficient immune reaction of the patient, or to a mechanical break of nature's barriers by manipulations or trauma.

The infection spreads through the lymphatics, small blood channels and directly through its entire thickness and soon thereafter the parametria and adnexa become inflamed and infiltrated. The loose fibroareolar tissues between the leaves of the broad ligament are swollen with edema and packed with leucocytes. This spreads under the pelvic peritoneum causing pelvic cellulitis and localized peritonitis. Pelvic thrombophlebitis is an integral part of this process.

Although the infection is still localized to the pelvis, there is great danger that spread to the general circulation may occur with resultant bacteremia of the entire body. The patient becomes increasingly ill and the temperature may rise to 102-103 degrees. The pulse rate is definitely increased and there is a complaint of lower abdominal discomfort. Direct and rebound tenderness as well as some degree of muscle rigidity are encountered over the lower half of the abdomen, although the upper half is usually soft and unaffected. While a foul vaginal discharge may be present, bleeding is seldom encountered.

Category 3 — Once infection spreads beyond the pelvis, the patient becomes critically ill. Almost all mortalities occur in this group. The clinical picture varies according to the complications that develop. Hyper-pyrexia, shaking, chills and marked tachycardia are frequent.

Peritonitis — There may be a direct, and a lymphatic spread of infection so as to involve the entire peritoneal cavity. The typical picture of generalized peritonitis develops with distention, pain, vomiting, and dehydration. There is tenderness of the entire abdomen; no peristalsis is present; chemistry of the blood is markedly unbalanced; mortality is high. The possibility of perforated uterus must be entertained. The body attempts to localize the widespread purulence by forming abscesses. These most commonly occur in the posterior cul-de-sac, beneath the diaphragm, on the underside of the liver and between adherent loops of bowel, mesentery and omentum.

Septicemia — Most of the severe complications of septic abortion are caused by invasion of the blood stream with showers of bacteria and tiny particles of infected debris. Every organ of the body can be affected, and many small abscesses are formed as the pyemic process advances. Hepatosplenomegaly is common as well as hemolysis. Endocarditis is a complication, and pulmonary emboli are frequent. Nephron nephrosis or multiple cortical abscesses of the kidney are rare complications.

A complication which is being seen more often in recent times is bacteremic shock. This usually occurs in association with the sudden primary dissemination of bacteria into the blood stream and is characterized by acute hypotension and a typical shock syndrome.

The purpose of this preparation is to consider the septic abortion from the standpoint of its significance, pathogenesis, clinical picture, complications, and management. The charts of 70 patients admitted with a possible diagnosis of septic abortion were reviewed during the period of 1957-60. These cases were evaluated on social and individual status of the patient, clinical signs and symptoms, laboratory findings, course and complications, and pathology reports, and finally management.

Results

Upon reviewing the 70 records submitted for study, under the criteria previously mentioned, it was possible to select only 15 cases which were able to be termed septic abortion. The cases excluded were on the basis of unreliable histories, pelvic inflammatory disease, and abortions associated with extragenital infection.

(CASES)

Evaluation of 15 septic abortion:

Age
Mean 28.4
Range 16-52

Pregnancy Status

	Parity	Gravidity
Mean	2.1	3.6
Range	0-8	1-9

Marital status

Single	Married	Separated	Divorced
4	9	2	0

Gestational age
Mean 10 weeks
Range 4 - 26 weeks

Temperature
Mean 101.4
Range 97.4 - 104.6

History of Interference
3

W.B.C.
Mean 16,400
Range 4,500 - 22,500

Urinalysis

Pus	R.B.C.	Protein
3.3	4.0	0.1 mgm

Friedman's

Pos.	Neg.	Not Done
4	2	7

Vaginal or Cervical swab

Done	Not Done
11	4

Organisms grown
E. Coli — 6
Staph. albus — 6
Monilia — 1
Non-pathogenic diphtheroids — 1
Trichomonas — 1

Grading
Stage 1 — 9 — 60%
Stage 2 — 4 = 26.6%
Stage 3 — 2 = 23.4%

Incomplete
7 — 46%

Inevitable
4 — 26%

Spontaneous
4 — 26.6%

The average patient admitted to this hospital with a diagnosis of septic abortion is 28 years of age, para –2, gravida –4, and more often married than not. She will thus be at a gestational age of 10 weeks and will have a temperature of 101.4 degrees Fahrenheit. In only 20% of cases will she admit to interference. She will have a history of lower abdominal pain associated with vaginal bleeding, nausea and vomiting, and back pain. On pelvic examination she will have an enlarged uterus which is tender, there will be a foul smelling discharge exuding from the cervical os, and more often than not will grow E. coli or staph albus from smear of this area. In 60% of cases the process will be confined to the uterus alone. In 46.6% the abortion will be of the incomplete variety, and the remainder will pass spontaneously. In this hospital the policy tended to be towards minimizing the infection before dilatation and curettage was performed. Blood cultures were done in only those patients who were very ill, and in those patients who gave a history of criminal interference. In two cases the blood cultures were positive; one grew Staph. aureus coagulase positive and the other E. coli. Complications which were seen in this series were pelvic peritonitis, septicemia, adnexitis, and bacteremic shock. There were no fatalities. Two patients gave a history of previous criminal interference, and two patients were seen again in hospital within a period of two years, and at this time showed chronic endometritis, or pelvic inflammatory disease.

Discussion

Septic or bacteremic shock is the most serious complication of abortion, and is reported to be seen more often in recent times. Since one patient in this series exhibited this syndrome, and because of the seriousness of the complication it is worthwhile to present the findings and history of the case.

A 36 year para 2 gravida 4, presented at this hospital on Monday, July 9/58 with a history of noticing a watery discharge two days previously after she had been doing heavy work. On the day previous to admission the patient noticed lower abdominal discomfort and continuing vaginal discharge. Her last normal menstrual period had been on March 26/58. The patient had been separated from her husband for one year. The temperature on admission was 105 degrees Fahrenheit. The patient did not admit to any criminal interference. Her past obstetrical history was relatively uneventful, except that she had had a previous miscarriage two years previously at eight weeks of gestation. On physical examination on admission, the patient appeared somewhat toxic and had an enlarged uterus consistent with 16 weeks of pregnancy. There was vaginal bleeding, and at this time the cervical os was tender on movement and there was uterine tenderness. The adnexa were within normal limits. At this time the blood pressure was 90/50. Three hours after admission the blood pressure suddenly fell to 70/55, the pulse rate was 132 and weak, and the heart sounds were also noted to be

weak. There were no signs at this time of massive bleeding — the patient had used only one pad since the time of admission. There was no evidence of intra-uterine hemorrhage and the abdomen was soft and non-rigid. Two units of blood and one unit of normal saline were administered intravenously but to no avail. The blood pressure did not change. Blood cultures were taken at this time, and ACTH was given intravenously. A levophed drip was started, and the blood pressure rose to a 100/60 but fell within three hours. The patient during this period became oliguric with a urinary output of 10 cc. since shock had set in. A dibenzylene block was performed, and within an hour the blood pressure improved as well as the intense vasoconstriction, and the urinary output improved. This was maintained for a period of 12 hours and then discontinued. All the while since admission the patient was on massive doses of S.R. penicillin and Achromycin intravenously. The temperature fell to normal on the third hospital day and remained normal. The patient was maintained on antibiotics and passed the fetus and placenta on the fourth hospital day. She received heparin and recovered uneventfully. Cultures of the cervix and those of blood were subsequently reported to be positive for E. coli. This case turned out happily for the patient and doctors, but Douglas reports five deaths in a series of six cases of septic shock.

Treatment

For many years a controversy has existed between the proponents of immediate uterine evacuation and those who believe that a conservative approach is more efficacious for the septic abortion. There are two schools of thought: the radical school actively empties the uterus within a few hours no matter how septic the patient may be; the conservative group avoids all intra uterine manipulation until the patient is afebrile. The method of treatment at this hospital favors the latter group. The management for each of the categories described is somewhat different.

Category 1 — These patients usually respond well to therapy and should have the uterine contents evacuated 48-72 hours after the temperature regains the normal level. As in all categories of septic abortion, vigorous curettage and the employment of intra uterine packing are contra-indicated. Such traumatic procedures break down natural barriers and spread infection.

Category 2 — The general management outlined is usually adequate for these patients, but they must be carefully nursed and re-evaluated. The uterus is gently evacuated after no less than 72 hours of normal temperature readings.

Category 3 — Almost continual vigilance is necessary for the woman whose infection has become widespread. Further specific measures are dependent upon which complications develop, as seen in the case history presented. While gas gangrene and tetanus infections are not common, these may occur following abortion. The treatment in addition to that for pyemia should include large doses of specific antitoxin and in some cases, panhysterectomy.

Summary

15 cases of septic abortion have been analyzed from the standpoint of significance, pathogenesis, clinical picture, complications and treatment. One additional feature may be brought out. That is, the overall incidence of septic abortion in this hospital is only 1.6% of all abortions (15/913). In most series, septic abortion is about 30% of all abortions.

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Special thanks to Miss C. Stankiewich and Medical Records Department of St. Boniface Hospital for their aid and co-operation in drawing and assessing the charts.

Independence for the Disabled

F. D. Baragar, M.D.
Medical Director, Canadian Arthritis and Rheumatism Society
S. E. Munro, O.T. Reg.

Occupational Therapy Mobile Workshop

Can your arthritic put on his shoes and stockings and get out of a chair by himself? Are you treating a multiple sclerotic who is unable to feed himself? Have you a hemiplegic patient who is unable to look after her family?

We tend to take the performance of these activities for granted. The inability to maintain independence in activities of daily living may contribute to emotional and psychological handicaps to the disabled person. Many patients gradually lose this ability to look after their own personal needs and often require considerable assistance from another person in the household or in the community. With the development of the Occupational Therapy profession, it is now being recognized that disabled people can regain or maintain their independence with modifications in their environment and the provision of specially designed devices to augment their remaining function.

In Manitoba, until recently this service was only available in a limited number of hospitals in the Winnipeg area. The Canadian Arthritis and Rheumatism Society with the assistance of a Federal and Provincial grant, has obtained the services of an Occupational Therapist and a mobile workshop. This will provide for the first time, an Occupational Therapy service in patients' homes throughout Manitoba. Initially, this service will be limited to providing assistance in improving the patients' independence by alterations in the home or the provision of aids. Because of the area to be covered and the shortage of trained staff, it is our opinion that it would neither be feasible nor practical to provide a home-bound remedial craft program.

There is an infinite variety of medical conditions which can handicap individuals in their every day activities. As the medical profession becomes aware of the potentials of this service, the variety of cases referred will undoubtedly increase.

One class of patients which we encounter regularly, is the cerebral vascular accidents with residual hemiplegia. The housewife, confined to a wheelchair, can often continue to manage her household duties with minor alterations to the kitchen and instructions in how to manage her tasks from her chair. Functional limitation of one hand, especially the dominant one will demand considerable re-education and often the provision of devices to facilitate holding. For example, a double suction cup attached to a bowl and to the table top, enables the patient to continue baking; a special board with spikes to hold vegetables will permit her to prepare a normal meal. Similarly, a one-handed can opener or egg beater may be necessary.

Several types of patients have feeding problems either through loss of joint movement or muscle weakness. A patient with a stiff elbow, who cannot get his hand to his mouth, can often feed himself with the provision of a long handled spoon. Specially adapted eating utensils can overcome deficiencies of grip. The woman unable to comb her hair, can regain some of her self respect by the addition of a long handled comb for grooming.

The inability of a patient to get up from a chair without assistance markedly restricts independence. The therapist by raising chairs and toilet seats, and by the judicious use of rails and bars, can again make it possible for this patient to care for himself. The daily chore of putting on shoes and stockings can be insurmountable for many arthritics, but special shoe laces, shoe horns and devices can again make these tasks possible.

These illustrate a few ways that the Occupational Therapist can further your patient's independence. The provision of the mobile workshop will make it possible for patients to be seen in their own homes and the difficulties and needs assessed on the spot. The workshop contains the necessary materials and tools for the provision of these gadgets and alterations. The therapist can then instruct the patient in their optimum use all at the time of the initial visit. In most cases, a follow-up visit will be necessary at a later date.

This service is now available in Manitoba at the request of the patient's physician. There is a nominal fee for service but no patient will be denied assistance because of inability to pay. Referrals or questions regarding this service should be directed to: The Canadian Arthritis and Rheumatism Society, c/o King Edward Hospital, Winnipeg 13, Manitoba.

Ophthalmology

Pleoptics

A New Treatment for Some Types of Lazy Eye

J. E. L. Bendor-Samuel, M.B., D.O.M.S.

Binocular vision, like walking, is a skill that a growing child must acquire. A child with strabismus at first experiences diplopia, but soon learns to suppress the vision in the squinting eye. Such suppression takes place at the macula. Vision begins to fail and the eye becomes amblyopic. Peripheral vision is not suppressed.

In any person with two eyes, it is obvious that any one point in the retina of one eye must have a corresponding point in the other eye. Scobee defines corresponding retinal points as "those points in the two eyes which have the same visual direction." Under normal circumstances, the corresponding point of the macula is the opposite macula. When, however, a strabismus is present, the corresponding point of the macula in the fixing eye is a point in the retina of the fellow eye other than the macula.

When a strabismus remains uncorrected over a long period of time, not only will the vision of the macula of the squinting eye be suppressed but the patient will attempt to fix with this corresponding point or "pseudo-macula." Such a patient even when the functioning eye is covered will continue to fix "eccentrically" with this pseudo-macula. Eccentric fixation can never, of course, lead to good central vision as the point of fixation lacks the anatomical structure of the macula.

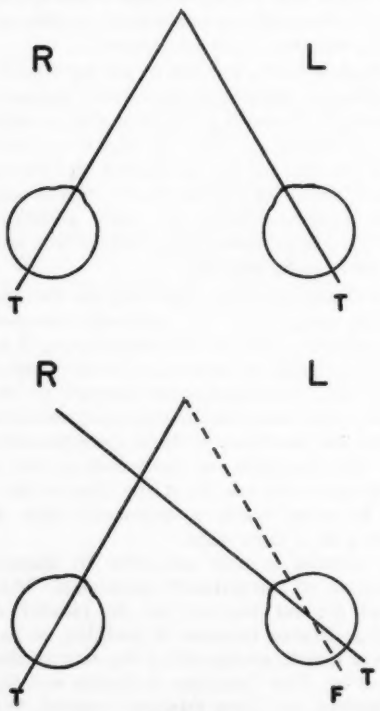


Figure I

T=True Macula F=False Macula

A child with amblyopia is treated by covering the non-amblyopic eye with a patch. This encourages the use of the macula of the "lazy eye" and, if it is done early enough, vision improves. Once eccentric fixation has developed, however, covering of the non squinting eye is valueless, for the child will continue to fix eccentrically. In the past there has been no satisfactory treatment for ambyopia associated with eccentric fixation.

Recently a method of treatment known as Pleoptics has been developed on the continent of Europe and is now being introduced into this continent. An eccentrically fixating eye has two defects, suppression of macular vision and development of the pseudo-macula. The principle of Pleoptics is suppression of all non macular vision by means of dazzling the retina everywhere except at the macula and stimulation of vision at the macula only. For this purpose several instruments have been devised.

The Visuscope is an instrument of diagnosis. By its means a small disc of light is projected on to the retina, while the latter is observed ophthalmoscopically. With the opposite eye occluded, the patient is asked to fix the ophthalmoscope light. The disc should then cover the macula; if it does not do so, eccentric fixation is present. In some instruments the disc is surrounded by a series of concentric circles and the distance of the fixation point from the true macula may be computed.

Once the diagnosis has been established the eccentrically fixing eye must be occluded and kept occluded constantly except during treatment. Thus active suppression of the macular vision will cease, and no effort will be made to see with a pseudo-macula.

Treatment is begun with the Euthyscope or the Pleoptophore. By these instruments a light may be directed on to the fundus illuminating a wide portion of the central area except for the true macula which is covered by a dark disc. In this way all the retina except the macula is dazzled and when the light is removed the macula is the only part of the eye which is able to perceive objects under ordinary illumination. Any attempt at vision must be carried out by the macula and by that alone. The patient is encouraged to look at letters of varying size, while a light flashes on and off the screen, and stimulates vision.

Another instrument that may be used during the period of dazzle is the Co-ordinator. This instrument depends upon a physiological phenomenon known as "Haidinger's brushes." If a point of light is viewed through a rotating polaroid filter, it will be seen as two brushes or a rotating propeller. This appearance can only be seen by the macula and is probably due to the arrangement of the fibres in that area. If a patient sees the phenomenon, he must be using his macula.

Pleoptics offers a method of treatment for a class of patients for whom little could be done in the past. The conventional treatment of amblyopia in a normally fixing eye offers little hope of success after the age of seven years. This is not so with pleoptic treatment. Indeed, the child needs to be of an age where active co-operation is possible. It must, however, be emphasized that the treatment is prolonged and tedious. It is useless to embark on it, unless the patient (and the parents if he is a child) as well as the therapist is prepared to persevere for many months. The key to success is the desire to succeed. When it does succeed it offers restoration of useful vision to a hitherto non functioning eye.

Geriatrics

Chronic Care

Dr. Asa MacDonell
Deer Lodge Hospital

Introduction

With the increase in the proportion of the aged in our population, the terms "chronic disease" and "chronic care" are coming into common usage. However, it is essential to differentiate between the two. In the first place, chronic disease is very common. For instance, most of us in this room have at least the beginnings of a chronic disease (arteriosclerosis). Yet it is not the presence of a chronic disease which predicates or which determines the requirements for chronic care. Rather, chronic care is required when the individual is no longer able to cope with the challenges of the environment in which he has been living, because of an altered relationship between his functional capacity, his medical status and his social environment. This pertains in our discussion of the aged individual.

Definition

My definition of chronic care is as follows—Chronic care is that type of assistance which will maintain or improve the medical disorder, the functional capacity and the social competence of the aged individual. It is immediately obvious from this definition that chronic care can be divided and considered under two principal headings:

1. Institutional chronic care, which has to do in the main with medical disorder and functional capacity.
2. Community chronic care — which has to do in the main with social competence.

As the discussion proceeds I hope that it will be abundantly clear that although two divisions are obvious, yet in order to provide continuity and effective care of this type there must be an intermingling of the institutional and the community interest and activity.

Address to the Conference — "The Church and the Aged"

Institutional Chronic Care

In preparing for this discussion I sought the advice of a consultant—an oldster—my father-in-law, and I would like to quote you some of his remarks, for in them I think lies the key to so many of our problems with chronic care and, indeed, with the elderly. He said, "For the elderly it is essential to provide for continuity of activity as, for instance, between work and retirement. Otherwise the elderly tend to get lazy, their interest in physical and mental activity decreases. If they don't get the challenge in time, the longer the delay the more difficult it is going to be to have them meet any challenge."

From the institutional point of view, perhaps a problem may be stated in the form of a case history. A 65 year old man who lives with his wife in a second-floor suite of an apartment building falls unconscious to the floor of the bathroom while shaving one morning. Within an hour he is taken to the hospital by ambulance. There a left hemiplegia is diagnosed and he is admitted to the hospital ward. Over the next 24 hours he slowly regains consciousness, but no useful movement of his paralyzed limbs. Let us now review the care requirements of this case at its various stages.

During the first 24 hours of his hospitalization he requires full nursing care and supervision—attention to the vital signs of blood pressure, pulse and respiration, suctioning of secretions, intravenous feeding and frequent linen changes. On his resumption of consciousness, however, he resumes the need for the challenge of physical and mental activity. His paralyzed limbs should be moved, he should be assisted to feed himself. Thus, his requirements for full nursing care and supervision are showing the first evidence of being superseded by the need for the measures of functional resitution. Within 96 hours his voluntary movement returns in his left leg and by this time he has been taken out of bed and given the opportunity to stand

with support and assistance. A week after the onset of his illness he has slight movement in his left hand and can almost get from a sitting to a standing position by himself. From this time on, concerted efforts to obtain functional competence must be made with rehabilitative measures. Now, too, is the time for realistic assessment of his social needs and his potential physical capabilities. At the best it would be nice if he could climb the two flights of stairs—one short and one long—from the street level to his suite, be able to dress himself, feed himself, get in and out of bed, and to the bathroom. An intermediate goal would be to get about the suite by himself with minimal assistance. A minimal goal would be that of wheelchair ambulation with assistance, such as his 60 year old wife could provide in this and his other activities of daily living.

Discussion

Hence our case received early medical assessment and treatment, which is the first requisite of chronic care. Secondly, a program of functional restitution was instituted early with passive movement of his paralyzed limbs, getting him up in a chair, encouraging him to feed himself and later giving him the opportunity to stand by himself. All this while contact has been maintained with his social environment by explaining his progress to his wife. Sometimes the hopeful goal of his social competency within his home environment is modified, for it happens, of course, for one reason or another, that return to that environment is not always possible. Under such circumstances, another facility such as an Old Folks' Home or extended stay accommodation must be substituted. However, whatever the facility, the same principles of care must be enforced, namely to provide continuing measures for the restitution and exercise of functional ability.

Conclusion

Thus the principles of chronic care in an institution should be the evaluation of the medical and functional disorder on the one hand, with their restitution by appropriate measures on the other, bearing in mind the social environment. An attitude of optimism must prevail and the static custodial attitude avoided, for bed rest leads to deterioration. Physical and mental challenge should be provided. Both preventive and remedial measures are essential in the community as well as in the institution.

Just before handing over the discussion regarding the community aspects to the other members of the panel, I would like to leave you with this thought. You can build all the institutions for chronic care which an affluent society can provide, you can provide all the funds for public welfare which that economy can afford, and yet still fail to provide the enlightened and progressive assistance required if you do not have the dedication and interest of the personnel dispensing that care.

Obstetrical Memoranda

The Case of the Lost Placenta

M. Bruser, M.D.
Chairman, Department of Obstetrics and Gynecology, Misericordia General Hospital, Winnipeg, Manitoba, Canada
Z. Matwichuk, M.D.
Interne, Misericordia General Hospital, Winnipeg, Manitoba, Canada

The obstetric consultant, on being called in to help in an emergency case where the placenta cannot be found, is entitled to admit to at least a momentary confusion. The consultant in this case will never forget his dreamlike sensations as, with his fingers inside the uterus, he searched under towels, sheets, drapes, and even in the "bucket" for the missing placenta. It just wasn't anywhere! Obviously impossible, until the continuing searching fingers in the uterus reached the top of the fundus and located the hole there.

Case Report

Mrs. B. L., a white housewife, 35 years of age, gravida IV, para II, was admitted, in labor, to the Misericordia Hospital in Winnipeg, Manitoba on September 28th, 1960. Her last menstrual period had begun on December 6th, 1959. The expected date of delivery was September 13, 1960. Menarche at 15 years of age. Cycle regular, 4/28 days. Had never had a pain in conection with her periods. She had uneventful full term pregnancies with normal vaginal deliveries in 1954 and again in 1956, when healthy children were born. There was a miscarriage in 1957 in the 3rd month of gestation. The previous medical history was non-contributory.

During her present pregnancy she had no family doctor and attended no prenatal Clinic; and was only seen in the Misericordia General Hospital four hours before confinement at 42 weeks of gestation. On hospital admission the patient appeared to be well nourished and in no distress. Her B.P. was 110/80 and pulse 75/min. Examination of the abdomen revealed a full term pregnancy with fetal head well engaged, ROA. The fetal heart tones were heard in the R.Q. below the umbilicus. Rectal examination indicated presenting part to be a vertex low in pelvis. Duration of the 1st stage was 13 hours and 7 minutes. Cervix was fully dilated at 2:00 p.m. and she was prepared for delivery. On

vaginal examination position and presentation were confirmed. Second stage ended at 2:15 p.m. with duration of 8 minutes. Healthy female infant was born spontaneously with birth weight of 7 lbs. and 6 ozs. Minimal bleeding after completion of the second stage.

In the third stage, after waiting for 25 minutes the placenta did not separate. Attempted mild simple expression failed. It was decided to remove the placenta manually. The umbilical cord was followed to the fundus but the placenta was not felt in the uterine cavity. At this time the Obstetric consultant was notified. While trying to locate the placenta, the cord, which was being held in the other hand became separated and fell off into the vagina.

When the consultant arrived, the scene in the delivery suite was quite normal and quiet. A comfortable, happy patient lay on the table, delighted with her new baby but a bit puzzled about being up in stirrups so long. There was no bleeding, her B.P. was 120/70, her pulse 80, she was peacefully happy; and there was no abdominal pain, tenderness, or rigidity. The uterus felt like that of all other immediate post-partum uteri. There was no indication that anything was amiss, except that in the placenta basin lay 19" of umbilical cord, no blood and no placenta. Being confident that the placenta must be in the usual place the consultant casually prepared for the usual manual removal—when the events described in the opening paragraph transpired. The hole in the fundus admitted two fingers readily and the rim felt smooth and firm, closely resembling the sensation one associates with a tight internal os. There was no apparent need for urgency: time was taken for further consideration. It is well known that in cases of intra-abdominal pregnancy it is often (perhaps usually), the best policy to leave the placenta in situ to be dealt with by natural processes. In this case, we did not know whether the placenta was attached intra-abdominally, that is to say, a sort of combined intra and extra abdominal pregnancy—but on consideration it was decided that this was rather unlikely. The dreamlike quality of the situation persisted.

If the placenta was lying loose in the peritoneal cavity, would the same "natural processes" deal with it so easily, or would this patient be in for a long and stormy and possibly dangerous convalescence? So laparotomy was decided upon. Under close observation no need for urgency arose, and after suitable preparations, laparotomy was performed at 10:00 p.m., i.e. 8 hours after delivery. The patient was in perfect condition, her status being in no way different from that of any other post-partum patient, e.g. B.P. remained at 120/75, pulse 75.

Several photographs were taken during and after the operation: (Figs. 1-4). Note particularly

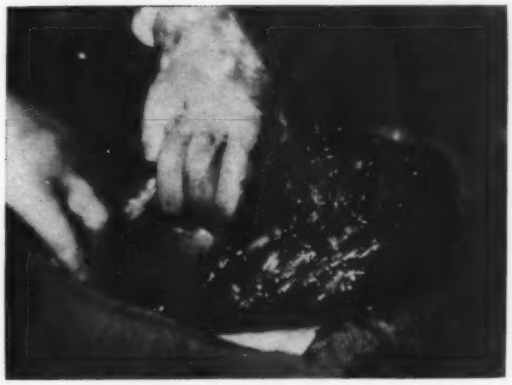


Figure 1
Placenta being raised out of abdominal cavity.

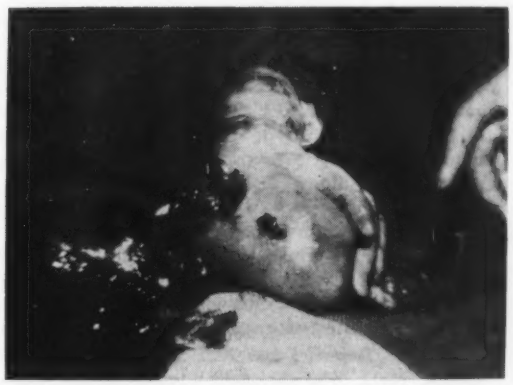


Figure 2
Uterus delivered from abdomen showing the defect.

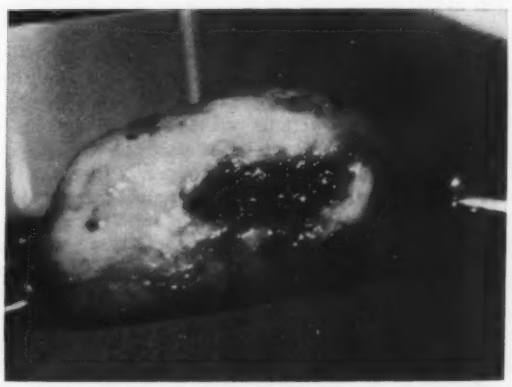


Figure 3
Showing the hole in the fundus of the uterus.

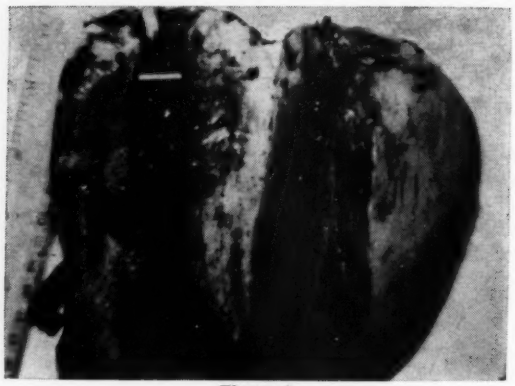


Figure 4
Uterus opened through the hole.

that these photographs clearly show, as does the description of the pathologist, that this was an old rupture of the uterus: the rim being firm, fibrotic, bloodless, and the endometrium being practically fused with the peritoneum of the corpus all around the periphery. The hole at this time appeared to be possibly 10 x 3 cms. lying horizontally. The placenta lay loosely rolled up under the liver, and was simply lifted out of the abdomen. There was one "violin string" type of adhesion proceeding from the rent to the greater omentum. There was no free blood or amniotic fluid seen in the peritoneal cavity. In order to ensure healing of this large hole, an operation equivalent to fundectomy would have been necessary; and this would have left a dangerously crippled and probably useless organ behind, so hysterectomy was performed. Her third stage lasted over 8 hours.

Report From Pathologist

Gross: No. 1. The specimen consists of 800 grams of ruptured, postpartum, uterus measuring 13 cm. in width by 7 cm. in thickness, 12 cm. in length and having a dilated cervix approximately 4 cm. in length by 7 cm. in diameter, the cervical os being soft and patent to 5 cm. in slit-like fashion. Situated at the upper pole of the uterus is a tear 5 cm. across x 1 cm. in width running horizontally. The endometrial cavity is completely continuous with the serosal coat through the rupture site and the cavity is lined by shaggy blood clot.

Representative sections put through—4 buttons.

No. 2: The specimen consists of a 430 gram placenta supplied in a shallow pan without adequate covering by formalin, extensively desiccated mass, 15 cm. in circumference and showing absence of the cord which was avulsed on the insertion which was approximately 4 cm. in eccentric fashion from one margin (velamentous). The fetal aspect is not otherwise remarkable. The membranes are ruptured. On maternal aspect the tissue was broken down into about 20 fairly sharply demarcated cotyledons. No evidence of infarction was seen at any point of the surface of the rupture. Representative sections put through—2 portion 1 button. CMC.

Microscopic

Sections of the uterus reveal hypertrophic uterine musculature with the placental implantation site consisting of mature decidual tissue and chorionic villi. There is considerable hemorrhage at this site. Sections through the area of perforation are lined by focally hemorrhagic muscle in which no evidence of extensive necrosis can be identified. There is a slight scattering of polymorphonuclear leukocytes throughout the entire musculature of the uterine fundus but no specific necrosis can be identified of recent type through the area of perforation.

No. 2. Sections of the placenta reveal mature decidual and chorionic placental tissues. The gross placental site sits partially astride the hole in the fundus, though it lies largely on the left lateral wall.

Diagnosis

1. Rupture of the uterus (remote)
2. Placenta.

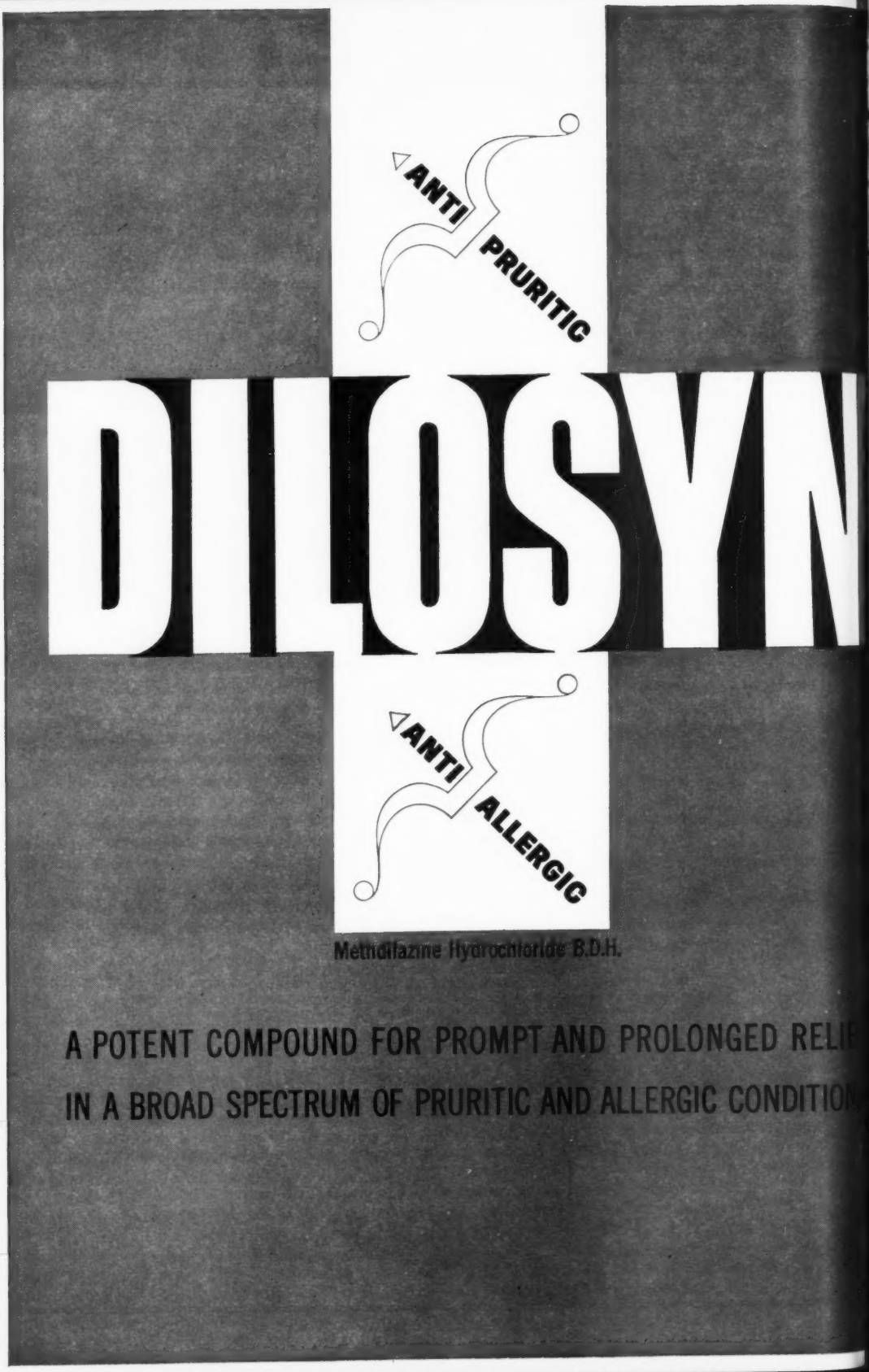
Discussion

Frank talks were held with the patient and her husband, and it was learned that the abortion in 1957 had been induced by instrumentation. It was obvious that the normal situation of ruptured uterus did not apply here. One assumes that it was the fortuitous position of the placenta over the hole in the uterus that helped to determine that it would be the cervix which dilated and not the contracervical orifice. But then why did this not bleed, as a placenta praevia should? And one may be bemused by the contemplation of the various pressure factors involved, which determined the direction of the expulsion of the fetus and placenta in (suitably) opposite directions. Furthermore, here was a huge hole in the top of a normally menstruating uterus for nearly 3 years. There was no dysmenorrhoea and we were unable to find any evidence of endometriosis in the abdomen. The hole was not, at time of operation, plugged by adherent omentum nor was there any evidence that it ever had been. The strange quality of unreality persists, one wonders at the various interesting factors; but such speculation is perhaps idle.

Summary

A case is described in which through a preexisting hole in the fundus of the uterus the placenta entered the peritoneal cavity probably coincident with the delivery of the fetus via partes naturals—there was no shock and no bleeding: the only evidence of any disorder was the absence of the placenta and a palpable rent in the fundus uteri. An attempt is made to describe the unusual impact of such a case on the persons concerned.

We should like to express our sincere appreciation to Dr. A. Goodwin for his generous, altruistic and excellent photographing efforts.


ANTI
PRURITIC
DILOSYN
ANTI
ALLERGIC
Methdilazine Hydrochloride B.D.H.
A POTENT COMPOUND FOR PROMPT AND PROLONGED RELI
IN A BROAD SPECTRUM OF PRURITIC AND ALLERGIC CONDITIO

Dilosyn is the B.D.H. preparation of methdilazine hydrochloride, a novel antipruritic—antiallergic agent. Its significantly prolonged duration of action is due to an inherent affinity for tissues. Tissue levels of Dilosyn are maximal about 30 minutes after oral administration, and excretion from the body is essentially complete in 24 hours. There is thus no danger of cumulative effects. (1,2)

Clinical studies have defined two major areas of usefulness for Dilosyn—antipruritic and antiallergic. Howell (3) reported exceptional antipruritic effectiveness in 80.6% of a series of 373 patients. Forty children, with pruritus due to atopic and contact dermatitis and chickenpox, obtained substantial or complete relief of itching.

Methdilazine is effective in a broad spectrum of allergic disorders (4,5,6). Symptomatic relief has been observed in the majority of patients studied. From animal studies (2), it may be reasonable to speculate that the "broad-spectrum" activity of Dilosyn is predicated on its ability to block the effects not only of histamine but also of serotonin.

Indications: Pruritic and allergic conditions regardless of etiology.

Dosage: 1 tablet twice daily for adults; 1 teaspoonful of syrup twice daily for children.

Caution: Dilosyn may cause drowsiness in some patients. It may also potentiate the effects of CNS depressants such as barbiturates and alcohol.

Supply: *Tablets* 8 mg. in bottles of 60 and 250; *Syrup* (4 mg./5 ml.) in bottles of 16 fl. oz.

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BDH BRITISH DRUG HOUSES

Editorial

S. Vaisrub, M.D., M.R.C.P. (Lond.), F.R.C.P. (C.), F.A.C.P., Editor

Canadian Medical Association Journal

> Embarrassment is easier to bear when shared with someone avec savoir-faire.
>
> —French Proverb.

That embarrassment is less acute when shared with someone more astute is obvious to anyone who ever had the occasion to experience this uncomfortable emotion. Indeed, were it not for a most distinguished co-embarrassee—the New England Journal of Medicine — our editorial blush could not be so easily extinguished. As it is, we were happy to note that the N.E.J. of M. shares with us the discomfiture of a belated congratulatory message. In its apologetic editorial of April 20, 1961, it congratulates the C.M.A.J. on the occasion of its 50th Birthday—four months after the happy event. We hope that the impact of this delay will blunt the sharp edges of our own procrastination.

We are also reminded of our disquisition on the validity of a certain cliché which served us well on a similar procrastinatory occasion seven years ago, and hasten to reprint it in toto:

"The time honoured adage 'better late than never' has, at best, a limited applicability. It offers little consolation to a traveller who on arriving at the airport a few minutes late sees his plane take off without him. It gives no solace to the student, to whom the right answer comes suddenly, as a wave of inspiration, only a few minutes after he has handed in his paper. Nor does it cheer the debater, who missed his chance for a brilliant repartee by a matter of seconds. Like the man on the flying trapeze reaching for the bar, these unfortunates would have been much wiser to adopt the motto of 'now or never.' There are, however, rare occasions which offer the slogan of 'better late than never' a range of usefulness. When, for instance, uttered as an apologetic remarks accompanied by a sheepish grin it may save the day for a groom arriving late for the wedding ceremony. It will often help to smooth over a belated birthday gift. May it, then, not be summoned to act as a "face saving" device for an editorial, commemorating an important fiftieth anniversary six months too late? Surely the grim alternative of waiting another forty-nine and a half years for the hundredth anniversary would appeal only to the young with their redundant life expectancies. Rather the embarrassment than the long wait."

Rather the embarrassment than the feeble excuse. Unlike the N.E.J. of M. we cannot justify our delinquency by blaming "a distracting winter of ill winds, convocations and sesquicentennial disturbances." Our Manitoba winters are singularly free of ill winds and disturbances of any kind, be they meteorological or political. No, we proffer no excuses. Ours is not to give reasons why, ours is but to eat humble pie and to wish the C.M.A.J. continuous growth and progress to the glory of Canadian Medicine.

Refresher Courses and Income Tax

Nervously thumbing the pages of a fashionable magazine (circa 1960) while awaiting our turn to be reprimanded by the Hospital Superintendent for neglecting to sign a case history, we came across the following passage: "Hiss's defiance perpetuates and keeps from healing a **fracture** in the Community as a whole . . . the case, according to Chambers, remains a central **lesion** of our time." Dazzled by the brilliance of these metaphoric gems, we turned our eyes to the television screen in the corner of the waiting room, only to be blinded by the glare of jewels cascading from the lips of a distinguished news commentator. "One cannot tell"—pontificated the pundit—"the **muscle tone** of a Cabinet from the **blood pressure** of the President" . . . "The **arteries** of American thought have loosened again." . . . We need hardly add that after the onslaught of this rich imagery, the remarks of the Superintendent to the effect that our neglect to sign records **clotted** the **circulation** through institutional channels, fell rather flat.

Yes, Medicine has arrived. It has invaded the language of the layman. Medical images, similes, hyperboles, metaphors and parables are mouthed by all and sundry with varying degrees of disregard for accuracy and aptness.

This infiltration of the language of the layman by medical imagery reflects the growing preoccupation of the public with problems of health. The average citizen is as keenly interested in coronary thrombosis as he is in interplanetary travel, and as apt to relate in the idiom of medicine as in that of nuclear physics.

Although justifiably proud of enriching the lexicon of the layman, Medicine has little ground for conceit, for she is only repaying a debt. Indeed the treasure chest of medical imagery is chuck full of sparkling coins borrowed from various oft-forgotten sources. The Dance of St. Vitus, The Fire of St. Anthony, the bruit of the Devil, the Mount of Venus, the head of Medusa, the murmur of the cooing dove, the hare lip, the bovine heart, the pigeon breast, the kissing ulcers, running sores, angry wounds, silent stones, galloping heart sounds —are but a few illustrations of this indebtedness.

Of the borrowed currency the most recent and significant are the coins minted in the realms of Industry, Business and Commerce. To the older

pulse **deficit** of auricular fibrillation and the oxygen **debt** of strenuous exercise have now been added the **cost** of breathing, **net** outputs, **production, consumption, balances, clearances, turnovers, pools** and **reserves.** Believe it or not, psychiatrists now speak of intellectual **capital** and emotional **money.**

It is obvious that the images of Business and Commerce, welcome as they may be in the house of Scientific Medicine, are much more at home in that of Medical Economics, where they are legitimate members of the terminological household Medical Economics is business; hence its language is the language of Business. It is, therefore, somewhat surprising that the words **buying** and **selling** are hardly ever encountered in the medical vernacular. Perhaps, this is so because the doctor views himself as a pursuer of a vocation rather than a purveyor of merchandise. Yet the two callings are not totally dissimilar. The analogy between the act of selling and that of dispensing the fruit of one's knowledge does not offend the imagination. Nor is the latter strained by a comparison between the acquisition of medical knowledge by the physician for future therapeutic application, and that of saleable goods by the retailer for subsequent distribution.

Indeed, we could pursue the analogy without overtaxing imagination nor credulity by pointing out the similarity between the periodic "buying trips" of the merchant to the centers where the sources of his supply are located, and the journeys of the doctor to the cities where the storehouses of his stock-in-trade — refresher courses — happen to be. The essential sameness of these two pilgrimages would appear obvious to the physician and layman alike. Yet, for some unknown reason, the similarity has not been recognized by our Legislators. While allowing deductions for buying trips to the businessman, our Department of Internal Revenue denies the privilege of similar deductibility for post graduate courses to the doctor.

It is with the view to correcting this injustice and obtaining an appropriate amendment to the Income Tax Act to permit practicing physicians to deduct the expenses of attending refresher courses, that a submission was made to the Honourable the Minister of Finance by the Canadian Medical Association on January 17, 1961. The full text of the submission, published in the C.M.A.J. of February 25, 1961, states the case for the Profession in terms of irrefutable logic. Let us hope it finds its due recognition by the Powers-to-be. Ed.

Book Review

Surgical Diseases of the Chest. Edited by Brian Blades. Publishers, C. V. Mosby, St. Louis, 1961. Price $22.00.

A formidable volume of literature in the field of thoracic surgery has accumulated. The contributors to Surgical Diseases of the Chest, present, in a single concise, legible volume, the salient features of modern thoracic surgery. The text is directed, "not only to surgeons, but to medical students and medical practitioners, who are interested in what can be accomplished in various diseases by thoracic surgery."

The book begins with a good discussion of surgical physiology in general with special reference to that of the heart and lungs, followed by a review of acid-base-fluid balance. The section on thoracic trauma is brief but concise and adequate. Management is specifically outlined. Little space is devoted to controversial issues. Indications for surgical intervention are clearly stated. These two chapters set the tone of the entire text. Each contributing author in turn, deals with a specific surgical condition by definition, statement of the pertinent clinical and diagnostic features, indications for surgical intervention and definitive therapy. Each author tends to describe the methods of management which in his hands, has proved satisfactory. A chapter is devoted to the surgeon's role in the management of pulmonary tuberculosis as it complements medical therapy. There is an excellent summary of the management of tuberculous disease of the pleura with indications for surgical intervention. There is a rather complete discussion of mediastinal tumors and surgical lesions of the esophagus.

The remainder of the book deals with lesions of the heart and great vessels both congenital and acquired. Following a brief review of cardiac physiology, specific heart lesions are systematically discussed, along with a very adequate description of extracorporeal circulation, the types of apparatus used, the technique of hypothermia and the physiological alterations associated with these techniques.

Surgical diseases of the chest combines the features of a concise, yet legible presentation. The index is good and the bibliography following each chapter extensive. The quality of the roentgenographic reproductions is excellent. The book fills a long standing need, in that it more than adequately presents a statement of the scope of thoracic surgery today. It is a fitting tribute to the memory of Evarts Ambrose Graham, to whom the book is dedicated.

M. B. L.

Obituary

Dr. Donald Gordon Coghlin

Dr. Donald Gordon Coghlin, 45, died at his home in Brandon, May 13th. Born in Strathclair, he received his B.Sc. in 1937 and graduated in medicine in 1942 from the University of Manitoba. About two years later he began practice in Winnipeg with Dr. F. G. McGuinness in Obstetrics and Gynaecology. He went to London in 1951 for post-graduate work and on his return began work with the Manitoba Sanatorium Board at Assiniboine Hospital in Brandon where he became chief of the department of internal medicine. He took a keen interest in the rehabilitation of Indians and Eskimo patients and was active in community life: Past President, Brandon and District Medical Society; Medical Director, Western Manitoba Division Arthritis and Rheumatism Society; Vice-President, Children's Aid Society; Surgeon Lieutenant, Royal Canadian Sea Cadets; member of Brandon Rotary and member of Brandon Lodge, A.F. & A.M.

Warm-hearted and generous, he will be greatly missed. He is survived by his widow, one daughter, his mother and two sisters.

Association Page

Annual Meeting

We are very pleased by the response from commercial exhibitors who wish space at the Annual Meeting to be held at the Royal Alexandra Hotel, October 10th to 13th.

More than 43 companies have indicated that they intend to exhibit and there will undoubtedly be others replying to our recent invitation to participate.

Royal Commission on Health Services

Although further information is expected in the near future, at press time the Commission's terms of reference have not been released, nor members appointed to the Commission, except the Chairman, Chief Justice Emmett M. Hall.

Planning at C.M.A. and Divisional level as to the method of presenting the profession's brief or briefs to the Commission is continuing and it is expected that a detailed report will be forthcoming in the very near future.

Mr. Justice Hall is a guest speaker at the C.M.A. meeting in June. His address "The Role of the Royal Commission on Health Services" will be heard on Medical Economics Day.

Who Reads the Review?

Someone at the Winnipeg Tribune undoubtedly does and to prove it we quote from the Tribune of April 13th, 1961:

"Manitoba's medical profession must either know all the answers, or else won't be bothered finding them out. On the question-and-answer page of this month's Manitoba Medical Review—the official publication of the Manitoba Medical Association—the journal turns tables by asking its readers a question.

Why, it asks, during the past 10 months has the magazine received only one question from its 950 members? "We don't have the answer," it answers. "Do you?"

"Review" Format Changes

At the last meeting of the Editorial Committee, certain suggested changes to the Review were discussed.

It was proposed that the size of the Review be increased to 8½" x 11" which would standardize the size with other leading Canadian Medical Journals. This uniformity lends itself to advertisers' requirements as they are able to use the same cuts for different magazines and possibly decrease their costs.

It was felt that a larger type would be more attractive on the larger page and would possibly be more easily read.

It was also suggested that the magazine be side-bound in order that the name and date of issue could be printed on the edge of the magazine which would be a change from the centre-stitch method currently used.

These suggestions were discussed by the Finance Committee and considered from a cost point of view. It appears from estimates obtained that the changes would increase production costs by approximately $2,000.00 per year.

It was felt by the Finance Committee, that unless the suggested changes resulted in greater revenue that it would not be advisable to make changes at the present time.

It was suggested that the Review remain at the present size but that it be side-bound and mailed without envelopes.

The side-binding would result in a small increase in cost but the saving in envelopes would off-set the additional amount.

The matter is to be further considered by the Editorial Committee.

Members' comments would be appreciated on these or other changes that they may have in mind.

Medical Library

We have received a request from the University of Manitoba, Faculty of Medicine, Library Committee, to consider an annual donation to the Medical Library.

The matter is under consideration by the Executive and an inquiry has been made of the Library as to whether or not there is any specific project the Association could undertake at this particular time other than a donation on a continuing yearly basis.

It would appear that the Library is currently faced with the problem of finding sufficient money for payment of student help in order to keep the Library open during the evenings throughout the summer and Saturday afternoons during the year.

Proposed Standards of Licensure for Hospitals

The Ad Hoc Committee established by the Executive to study the proposed Regulations under the Hospitals Act relating to Standards for Licensure has met on frequent occasions to review the 58 page manual.

The Committee has sought the opinion of the Sections and Medical District Societies on various points contained in the draft proposal and due to the extensiveness of the study an extension of the reporting deadline was necessary.

C.M.H.I.A. Combined Insurance Forms

We have been advised that at the time of reprinting these forms the assignment clause will be printed on the reverse side of the form. This has apparently been occasioned by popular demand.

The combined insurance forms may be ordered through the M.M.A. office.

Prepaid Medical Care

The C.M.A. Prepaid Medical Care Committee has completed studies that will culminate in a report to Executive Council detailing the coverage a comprehensive service plan should contain.

In addition, the report will include a recommendation that extended health benefits be developed by each plan.

C.M.A. Relative Value Fee Schedule

It may not be generally known that the C.M.A. Economics Division has been preparing a relative value fee schedule which it is hoped, will be ready for review this year.

We understand that as a research project, the B.C. Division has offered to make a survey using the Relative Value Fee Schedule. It is assumed that the schedule would be used by the profession in certain designated areas.

Workmen's Compensation Board

In December, 1960, arrangements were made for an increase in the Board's fee schedule, to cover an interim period January 1 to May 15, 1961.

It is felt that the new Manitoba Medical Association fee schedule would be available prior to the end of the interim period but as it was not possible to finalize the schedule at that time, the Workmen's Compensation Board has been requested to extend the interim period.

C.M.A.-M.M.A. Membership

The C.M.A. has recently forwarded a list of those in the Manitoba Division who have not renewed their membership for the current year.

The C.M.A. advises that it will be necessary to remove the names from the membership roll and the mailing list for the C.M.A. Journal if these members remain unpaid as of July 1, 1961.

You are urged to forward 1961 dues prior to the C.M.A. deadline in order to maintain continuity of membership.

M.H.S.P.

Hospital Insurance Premiums have been subject for much discussion during the past months. A new method of financing the plan is being sought particularly since the Premier promised to relieve the burden of hospital premiums on the lower income groups.

Observers feel that a graduated premium scale will be set up and linked with income tax in the event the province is allowed to collect its own.

Liberal Party Health Plan

At the Manitoba Liberal Convention held April 19th, 1961, the Manitoba Liberal Health Committee reported to the convention and outlined the Committee's proposals in respect to a proposed health program.

The Committee recommended that the Liberal Party express itself in favor of a non-compulsory prepaid comprehensive medical care plan. The financing of the plan to be by premium payment, and using a refund system based on Provincial income tax which is expected to be effective in April, 1962.

The plan would be operated by an independent non-profit medical care organization. This organization would be separate from Government, but premium rates and changes in coverage would have to be approved by a Government Accrediting Board.

Every citizen of Manitoba regardless of age or condition of health would be entitled to join the medical care organization on payment of the necessary premium which would be established according to insurance principles. Government contribution would be in the form of a tax rebate to each member of the medical care organization who paid a premium and filed an income tax return. The tax rebate would be based on the taxable income of the individual and would be determined in such a way that the smaller the taxable income the larger the tax rebate. The proposal suggests that the principle of the present Medicare program be continued and enlarged to cover those persons unable to pay the initial premium.

The Committee report states that the Committee believes the plan would be acceptable to the medical profession although the Association does not appear to have a record of being approached by the Committee nor having prior knowledge of the proposed program.

The Medical Care organization would be administered by a Board consisting largely of members of the medical profession of Manitoba. The proposed scheme, or at least the general administration, will be in the hands of the medical profession and the Committee recommends that the profession be reimbursed on a fee-for-service basis.

One interesting feature of the proposal is the suggested inclusion of the present M.M.S. principle whereby the medical profession absorbs a loss in the event of any excess of expenditure over revenue. This appears to be one feature the Committee recommended whole heartedly and we quote from the proposal:

"Consequently in any one year of operation if the premium rates are not sufficient to cover the costs of the plan, the doctors themselves absorb the difference. The Government would not be called upon to cover this retroactively."

New Party Health Plan

Recent press releases indicate the New Party advocates a National Health Plan covering medical, surgical, dental and optical treatment as well as drugs and appliances.

The Party document promises a comprehensive program of social security to ensure a standard of living which will enable every Canadian to live in health and self-respect.

It is suggested that the health plan would be built on the present hospital insurance program and would be evolved and administered in co-operation with provincial governments. The policy statement indicated that the plan would be financed partly by federal grants to provinces and partly by individual premiums graduated according to individual incomes.

R. P. H. S.

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Made in Canada

Questions and Answers Page

In order to keep the medical profession informed as fully as possible in all matters relating to Association business, medical economics and prepaid medical care, this page welcomes questions pertaining to these fields.

The problem of payment for medical care of indigent patients in chronic care institutions has been a matter of serious concern and study to the medical profession and various government bodies during the past two years. Herewith is an outline by Dr. K. Rankine Trueman, First Vice-President of the Manitoba Medical Association, of the situation as it is developing in Manitoba.

"In this province a situation has arisen, as it has in Canada generally, as the result of better control and treatment of tuberculosis. This has permitted the Sanatorium Board of Manitoba to make available hospitals at Brandon and The Pas for the provision of medical services to those requiring hospitalization for illnesses of a chronic nature. At the same time the reduction of tuberculosis patients has led to a loss of government grants to the Board. As a consequence of this, the Board is hard pressed to provide salaries for the doctors presently employed in a full or part time capacity in its hospitals. The latter are now largely filled with patients with a wide variety of chronic ailments requiring medical attention. Many of these patients are indigent and depend upon the services of the hospital medical staff. The proportion of indigents in the Assiniboine Hospital at Brandon is about 83 per cent. The facilities of the hospitals are available to all doctors who may wish to supervise the care of their private patients. In addition to hospitals controlled by the Sanatorium Board, the Municipal Hospitals operated by the City of Winnipeg, fall into the category of chronic care institutions. Presently the amounts available for salaries to doctors in the foregoing institutions are, as mentioned, quite limited. In one case it is about three per cent of the total budget and it is never higher than six per cent of the total budget.

"Confronted with the difficulty of maintaining adequate medical services and staff because of dwindling resources, the Sanatorium Board and the Department of Health and Public Welfare have sought the support of the Manitoba Medical Association. The problem at issue involves the payment by hospitals for medical services the hospital may provide. Apart from X-ray, pathological and laboratory services, the profession is opposed to such a practice on principle. However, funds are now available for the payment of medical services in the case of prolonged or chronic illness through a shareable arrangement between the federal and provincial governments. Such funds could be supplied the Sanatorium Board to pay its medical staffs adequately. This matter presently is under review by the Canadian Medical Association. The Manitoba Medical Association understandably would wish to be guided by the decision of its parent body.

"The volume of patients receiving care for chronic illness at any age will increase in numbers and also in proportion to the total population. This is so not only because people are surviving longer but because appropriate care will become increasingly available and chronic hospital accommodation will be made more attractive. It may or may not be agreed that the medical services provided in these chronic care hospitals require some special training and a special philosophy not always needed in practice of medicine generally or in acute hospital practice. However, as a large part of the patients admitted will be maimed or old special interests in rehabilitation and geriatrics are certainly required of those who provide the medical services in these institutions. It would appear that a process of evolution is determining who will provide the services. Factors which are responsible depend partly upon the relative isolation in which chronic care hospitals are situated. Others probably arise from a disinterest among some doctors to practice rehabilitative or geriatric medicine. Since most doctors are busy with many things some are satisfied to turn over the care of the patients they admit to the chronic care hospital to doctors who are already on the spot and established. The latter may also be better qualified by background and interest to do the work. However, as the hospitals welcome the presence of the attending physician he is in a position to continue to supply the care of his patient with only occasional consultation with a member of the medical profession administering the hospital.

"It is likely that the practice of this type of referral to the permanent staff will continue. However, it may be affected by the establishment of facilities of this nature close to active hospitals as is planned. If the former is so the authorities and the medical profession must assure the best medical services for the inmates of these facilities providing chronic care. To make the work not only attractive professionally but also to encourage individual doctors to enter this field of endeavour proper accommodation and services must be available and a proper monetary return assured. It is accepted that the facilities will provide best care if doctors are able to give continuous or regular attention to the patients. For foregoing reasons the patients are best served by full time or part time doctors.

"Presently an uncertain situation exists. Doctors are needed in the chronic care hospitals directed by the Sanatorium Board of Manitoba to treat sick people. The Board does not have the resource to to pay adequate salaries to the doctors. In order to improve salaries the Manitoba Medical Association and the Board agreed salaries could be supplemented by a charge on the patient at a specific amount. The result was collection of a modest sum. It is unlikely that it is sufficient to satisfy or maintain the doctors in their present positions. Paradoxically the Provincial Government is willing, with assistance from the Federal Government, to contribute funds to the budgets of the Sanatorium Board hospitals to pay appropriate salaries to the doctors involved. This would be administered through the Manitoba Hospital Services Plan. Let this be done and regarded as a minimum salary, at a proper level to compete with the return from general medical practice. To supplement this minimum, fees may continue to be charged for medical services rendered patients able to pay. The fees should be collected by the hospital at a small service charge. This should be so if for no other reason than to determine if the returns from such practice are appropriate, too little or too much, for the amount of service provided. The guaranteed salary and the probability of a bonus should result in obtaining good doctors with special training and interest in a unique field of medical practice generally shunned by the profession in general. If this is agreeable it should be understood that this involves a situation limited to the care of patients in hospitals constituted for the prolonged care of patients with chronic illness. The adoption of such a practice in active care hospitals open to all doctors and generally used by them in the provision of medical services is in no manner approved by this recommendation.

"This conclusion is reached on the understanding that the Provincial Government is not prepared either to extend the benefits of Medicare to in-hospital medical services for social welfare dependents nor to consider assistance to those regarded as para-or medically indigent. Should changes in government policy be forthcoming a revision of our attitude may be indicated. In adition in order to facilitate the payment of fees by those with Manitoba Medical Service an agreement should be made between the Medical Association and the Manitoba Medical Service that the charge made by the hospital on behalf of a patient and a doctor be recognized.

"The matter has had the close attention of the Association through its Economics Committee. Extensive studies were made by a sub-committee under Dr. A. R. Tanner. Meetings were held with officials of the Sanatorium Board, the Minister of Health and Public Welfare, the Municipal Hospitals of Winnipeg, the Winnipeg City Health Department and the Manitoba Hospital Services Plan. As a result the Economics Committee, with Dr. L. R. Rabson as chairman, made the following recommendations on May 24th to the Executive Committee of the Association:

"1. That those patients who are confined to chronic care institutions and can pay for medical care should do so.

"2. That the payment for medical services to indigents in chronic care institutions be a cost under the M.H.S.P. That we agree to this situation only on a temporary basis for the following reasons:
   (a) C.M.A. is studying the matter in a joint committee with the Canadian Hospital Association.
   (b) It is hoped that the institution of a prepaid plan in Manitoba will encompass tax-supported programs for the indigent and the marginal income groups. When this is accomplished such an arrangement as outlined above will not be necessary.

"3. Doctors working in these chronic care institutions should be guaranteed an income which may be supplemented by their collection of fees from those patients able to pay themselves or who carry medical care coverage through an insuring agency.

"4. Patients able to have their medical care bills paid for either by themselves or an insuring agency should have the right to the doctor of their choice.

"5. The agreement outlined above would imply that at all times these hospitals must be open to any qualified physician. In order to fulfill this concept it is necessary to ensure that within these institutions there is no difference in the types of beds and accommodation offered to those patients able to pay and those for whom medical care is being provided as a cost under M.H.S.P.

"6. That the situation be reviewed in one year.

"These recommendations are still a matter for study between the Manitoba Medical Association and the Board of the Manitoba Medical Service."

Manitoba Medical Association

(Canadian Medical Association, Manitoba Divison)

BRIEF

to the

Commission On Medical Education In The Province Of Manitoba

March, 1961

Extract from Order-in-Council No. 1289/60

Dated October 12th, 1960

WHEREAS under The Social Allowances Act, the government is authorized to pay from and out of the Consolidated Fund, for essential surgical and medical care for recipients of social allowances;
AND WHEREAS in making arrangements for the provision of such surgical and medical care for such persons apprehension has been expressed respecting the effect that the provision of such surgical and medical care for such persons might have on the teaching of medicine in the Province;
AND WHEREAS in making any arrangements for the provision of such surgical and medical care for such persons, the government has a responsibility to consider the ability of the University of Manitoba to offer medical students clinical training;
THEREFORE he, the Minister, recommends:
THAT under and by virtue of Part V of The Manitoba Evidence Act

1. Kenneth R. Trueman, M.D., John P. Gemmell, M.D., and Harold J. Riley, Q.C., all of the City of Winnipeg, be appointed commissioners under Part V of The Manitoba Evidence Act to inquire into all facts and matters respecting the provision of surgical and medical care to recipients of social allowances and its effect upon the teaching of medical students in Manitoba;

2. Harold J. Riley, Q.C., be appointed chairman of the inquiry;

3. The commissioners be empowered to regulate the procedure of the inquiry;

4. The commissioners upon completing the inquiry, shall report to the Minister of Health and Public Welfare on the evidence taken before them in submissions made to them, and their conclusions based on such evidence and submissions;

Letter to Members of the Manitoba Medical Association Dated November 15, 1960

Dear Doctor:

On October 12th, 1960, Cabinet - in - Council approved of the establishment of a Commission "to enquire into all facts and matters respecting the provision of surgical and medical care to recipients of social allowances and its effect upon teaching of medical students in Manitoba."

The Commission is composed of:

Mr. Harold J. Riley, Q.C. — Chairman

Dr. K. R. Trueman — representative of Manitoba Medical Association

Dr. J. P. Gemmell — representative of University of Manitoba, Faculty of Medicine.

Although the exact terms of reference are not immediately available, it was felt that this is such an important subject that no time should be lost in advising you that a Brief to the Commission is to be prepared by your Economics Committee.

It is anticipated that you may wish to contribute to the Brief. Please do so in writing as quickly as possible, directing your comments to the Association Office. The Committee will appreciate your prompt action and good advice.

Yours truly,
M. T. MACFARLAND, M.D.,
Executive Director.

Letter from the Commission on Medical Education Dated November 16th, 1960

Dear Sir:

Recently the Government of the Province of Manitoba has established a Commission to enquire into medical education. In broad scope, the terms of reference are to consider the education of prospective physicians in the light of changing economic status of the patients, so necessary in the clinical education of the student doctor.

In view of the interest of the Manitoba Medical Association in this matter, the Commission asks you to submit a brief for its consideration and permission to interview representatives of your association at the appropriate time.

It would be of great value to the Commission if the following topics could be covered in your brief:

a) The attitude of the Manitoba Medical Association to the current situation with particular emphasis to the recently introduced "Medicare" scheme.

b) Any proposals to ensure an adequacy of clinical material in the event that the "Medicare" scheme is enlarged to include payment to the private physician for both office and hospital care for all social welfare, indigent and "medically indigents" in the province.

c) The Commission feels that the problems of undergraduate and graduate (residency) training present rather different problems and the Commission would like an expression of opinion

on measures to ensure adequate training of residents.

d) In any extension of the "Medicare" scheme the economics of payment for patient care will be important. The Commission would like to know the attitude of the Manitoba Medical Association towards the payment of medical care given to patients on the teaching wards and out-patient departments of the teaching hospitals.

e) The Commission would appreciate an expression of opinion from the Manitoba Medical Association as to its responsibilities in the field of education of the future doctor.

Please regard the above as only suggestions as to content and feel free to include any other relevant material.

For the Commission to complete its work in any reasonable time, the deadline for briefs will be January 31st, 1961. As acting secretary, on behalf of the Commission, I have been asked to address this request to you.

Yours sincerely,
J. P. Gemmell, M.D.

Letter to Members of the Manitoba Medical Association Dated November 25th, 1960

Dear Doctor:

Within the past two weeks, you were informed about the establishment of a Commission to enquire into medical education.

Attached is a letter from the Acting Secretary of the Commission, suggesting topics that could be covered in the Association's brief.

Our previous communication indicated that the Economics Committee was drafting the brief. All material you have for the Committee in this respect should be directed to:

The Manitoba Medical Association,
601 - 404 Graham Avenue,
Winnipeg 1, Manitoba.

Please note that the Commission has set January 31st, 1961, as the deadline for receipt of briefs.

Yours very truly,
M. T. MACFARLAND, M.D.
Executive Director.

Introduction

The Manitoba Medical Association welcomes this opportunity to present its views to the Commission on Medical Education.

This Brief combines the opinions of the Executive, the written opinions of many individual members as well as those of the District Societies and several Sections of the Association, including the Section of General Practice and the College of General Practice. (Appendix 1)

Our members have a long tradition of interest and participation in Medical Education in this Province.

Historical Relationship

Twelve practising physicians appointed by the profession, were granted a Charter to form a College of Medicine of Manitoba by the Provincial Legislature in 1883. The original capital was supplied by the medical profession in cash and pledges and the first buildings financed by these doctors.

In 1895 the teachers received their first honoraria. Salaries were instituted in 1919 when the College became the Faculty of Medicine, University of Manitoba.

The Manitoba Medical Association

The Manitoba Medical Association, organized in 1908, is an autonomous division of the Canadian Medical Association.

It is a non-incorporated, purely voluntary association, membership being open to any qualified, licensed medical practitioner in the Province of Manitoba.

Fully qualified medical practitioners who are non-licensed, are eligible for membership if they are engaged "full-time" in medical teaching or research.

At present there are 950 members in the Association of a total of 1,116 doctors in Manitoba.

The Aims and Objects of the Association are:

1. "The promotion of health and the prevention of disease.

2. The improvement of medical services however rendered so that they may be available to all people.

3. The maintenance of the integrity and honour of the medical profession.

4. The performance of such other lawful things as are incidental or conducive to the welfare of the public and of the medical and allied professions."

Among its many standing Committees there is the Committee on Medical Education whose main function is to "study and report on pertinent matters in the field of undergraduate, graduate and postgraduate medical education."

(Ref. — Constitution M.M.A. 1960)

The Social Allowances Act and the Manitoba Medical Association

The Social Allowances Act became law on August 4th, 1959. The Manitoba Medical Association was consulted regarding the implications of this Act in November 1959. It should be recorded that the Association offered on behalf of its doctor-members, to continue gratuitous services to those unable to pay. However, in agreement with the Provincial Government, the Association accepted the present "Medicare" program as a temporary expedient until this Commission on Medical Education had made its findings. Under this program, in-hospital medical services are still rendered gratuitously by all doctors. Office and house calls are paid for through the non-profit Manitoba Medical Service. The Provincial Government pays the premiums for these Social Allowance cases. The patients however, may attend a hospital out-patient department and for these medical services there is no payment.

In October, 1960, the Commission was established to "enquire into all facts and matters respecting the provision of surgical and medical care to re-

cipients of social allowances and its effects upon the teaching of medical students in Manitoba."

The Commission on November 16th, 1960, elaborated its terms of reference and suggested various topics that could be covered by the Medical Association.

This Brief follows the elaborated terms of reference.

"Recently the Government of the Province of Manitoba has established a Commission to enquire into medical education. In broad scope, the terms of reference are to consider the education of prospective physicians in the light of changing economic status of the patients so necessary in the clinical education of the student doctor."

(Ref. — Commission letter 16 Nov. 60)

Section (a)

"The attitude of the Manitoba Medical Association to the current situation with particular emphasis to the recently introduced 'Medicare' scheme'. "

(Ref. — Commission letter 16 Nov. 60)

Medical education has been universally challenged by rapid changes in medical science and dramatic changes in medical economics, the latter reflecting changes in the general socio-economic sphere. This study is therefore both necessary and desirable.

Until quite recently the Faculty of Medicine has been frankly practical in its objectives; it was established to train General Practitioners of Medicine for Manitoba. The training of specialists and promotion of clinical and basic research have since become a function of the Faculty. The addition of these functions has occasioned an increase in staff far beyond that conceived by the twelve original founders and teachers. Today, three hundred and seventeen (317) persons are involved directly in the instruction of medical trainees. Two-thirds of the staff of the Faculty of Medicine or approximately two hundred and forty (240) practising doctors participate on a part-time basis in the clinical teaching of the undergraduate and postgraduate years. It is interesting to note that these clinicians form twenty-five percent of the profession licensed to practice in Manitoba.

The teaching of basic sciences in medicine has not been affected by economic trends. Clinical teaching, however, can only be carried on by patient-demonstration. It is in this field that economics has directly affected medical education.

The clinical teaching of medical students traditionally has been conducted on indoor and outdoor patients unable to pay for their medical services. The practising physician, part-time teacher, has successfully participated in this program and has given his services to these patients without any recompense. Following accepted traditions, compensation for his loss of time and service was obtained by the use of a sliding scale of fees to those patients in his private practice able to pay. This situation is now markedly changed.

Approximately one-third of the population of Manitoba, the majority living in the area from which "teaching-patients" originate, receive prepaid medical services through the Association sponsored Manitoba Medical Service. An additional number, bringing the total to about half the population of Manitoba, receive varying prepaid benefits from other carriers.

This trend towards participation by the total population in prepaid medical services insurance is a manifestation of current socio-economic philosophy. The Manitoba Medical Association supports the Statement of the Canadian Medical Association (1960) that Medical Services Insurance should be available to all. (Appendix 2) We believe that prepaid medical services are best provided on a voluntary basis through doctor-sponsored non-profit organizations. Tax-supported programs to provide such prepaid care are only necessary for those unable to pay their own premiums.

It becomes apparent, therefore, that most people seeking medical care will do so as private patients. The traditional concepts of clinical teaching have and will change markedly. The problems presented by such changes can be solved in a way that will preserve the high standards of medical care and also the high standards of clinical instruction, as outlined below.

The Association has co-operated with the Provincial Government in the difficult problem of providing medical services for the indigent. Utilizing the facilities of the non-profit Manitoba Medical Service, their combined efforts have resulted in the presently constituted "Social Allowances Medicare Scheme."

"Medicare" does not appear to have decreased the number of patients for teaching. Letters from the major teaching hospitals indicate that the out-patient clinics have grown in numbers and the staff wards are full most of the time. The effect of the present unemployment situation is difficult to assess in this regard.

Nevertheless those coming to the out-patient departments and to the teaching wards, whether covered by "Medicare" or not, are for the most part in the over-65 age group and present the limited pathology peculiar to that group.

It is our opinion the present "Medicare" plan as a means of providing medical care to people is unsatisfactory. It is our belief, and experience substantiates this, that it is difficult if not impossible to convey to most people the concept of limited medical care coverage particularly to an indigent group That is, to convey this concept to them so that they fully understand it. Frustration suffered by both patients and doctors where only limited coverage for indigents exists, are so obvious as to require little comment. The term "Medicare" itself is confusing because although it implies only medi-

cal and surgical services coverage it actually encompasses dental services, optical services, drugs and other remedial care. The patient is further confused in that his "Medicare" card issued by the Manitoba Medical Service implies that all such services are insured by that organization and this is not the case.

The present plan is most irritating to many patients. Most rural patients on "Medicare" find that arrangements for transportation to teaching centres for investigation presents greater difficulties than before "Medicare" when they were treated in their own locale. Patients in urban centres, particularly Greater Winnipeg, are baffled by having to travel for drugs and investigative procedures, whereas formerly they could receive their total care through their private physician. In Greater Winnipeg, the necessity for patients to obtain drugs exclusively from hospitals has resulted in overwhelming objections.

If the object of "Medicare" was to preserve the dignity and self-respect of those individuals unable to pay for the medical care they need, it has failed to a considerable extent to meet this objective.

We favor and advocate the extension of comprehensive medical care to both indigent and para-indigent groups, the latter being marginal income groups. We believe this should be done in whole or part by means of a tax-supported program. Under this plan patients may receive all their care from a private physician or hospital out-patient departments, as they desire.

The classification of the so-called para-indigent is at present under study by the Manitoba Medical Association. The delineation of the para-indigent group must be a matter for negotiation between the Provincial Government and the Manitoba Medical Association. Such comprehensive coverage should be arranged through the non-profit Manitoba Medical Service, and tax-supported subsidy payments for this coverage should be a matter for negotiation between the Manitoba Medical Association and the Provincial Government.

Section (b)

"Any proposals to ensure an adequacy of clinical material in the event the 'Medicare' scheme is enlarged to include payment to the private physician for both office and hospital care for all social welfare, indigent and 'Medically indigents' in the province."

(Ref. — Commission letter 16 Nov. 60)

Adequacy of Clinical Teaching

In item (b) the Commission has asked for a solution to a hypothetical situation. If all indigents and para-indigents were to receive full prepaid medical insurance then all patients would be private patients. Clinical teachers would have to demonstrate with private patients.

We foresee few complications in teaching most of the clinical subjects.

Problems might be encountered in teaching procedures, e.g.: operative surgery, endoscopy and obstetrics.

The proposed solutions outlined below will assure a high standard of medical care to patients and also serve the teaching requirements of medical students, internes, residents and practising doctors. It will augment the number of patients available for teaching, and provide a more comprehensive cross-section of age groups and diseases.

In-patient Teaching Units

If all patients are private patients there is no further need for "staff" beds for non-paying patients but beds for patients required for teaching are still necessary.

The Association proposes the establishment of "teaching units" in hospitals now designated as teaching hospitals. The units would be under the control of the Faculty of Medicine, University of Manitoba. At present the hospitals to which this program would apply are the Winnipeg General Hospital, the St. Boniface Hospital and the Children's Hospital. Similar teaching units might be established later in other hospitals. Consideration should be given to those hospitals having living-in facilities for unmarried mothers. These hospitals would be useful for the teaching of obstetrics and gynaecology.

The teaching units would require approximately 300 beds in each general hospital which would be available to the patients of doctors who are members of the Faculty of Medicine. The remainder of the beds in the respective hospitals would be open to all doctors.

The Faculty of Medicine should retain the large number of part-time teachers now serving it. There are three reasons for this:

1. These clinicians would supply the majority of patients for the teaching units.
2. These clinicians would be encouraged towards advancement in medical knowledge and practice through the stimulus of the academic association.
3. The medical profession at large would attend the open wings of these hospitals and be exposed to the enrichment of an academic climate.

Such circumstances would permit the influence of the Faculty of Medicine to permeate the whole community for the benefit of all.

Each part-time teacher would be expected to admit as many of his private patients as required to the teaching unit. The unit must include private, semi-private and standard beds to provide a complete picture of hospital practice encompassing patients of varying economic status.

Each patient when admitted would agree in writing to be seen by students and to be treated by internes and residents under the supervision of their personal physician. This principle is in effect in other areas, where the majority of patients agree

and only an insignificant number refuse such terms of admission. This plan would increase the volume of patients for teaching and ensure a broader representation of age groups and diseases.

The chief of each service would be its recognized head and all members of the unit would be under his direction.

Out-patient Teaching Units (University Clinics)

The present Out-patient departments might contract or disappear, if all indigents and para-indigents were to obtain comprehensive coverage in a prepaid medical plan. Out-patient departments would no longer be required for the treatment of these patients. The sole reason for their existence would be the teaching of students. How could these essential units be continued? We believe the following suggestions are feasible.

1. Services at these teaching units would be available to all persons with or without referral: i.e.: University Clinics which would be in open competition with the medical profession at large.

2. It is anticipated that an increasing volume of people will attend these clinics by choice, particularly as the clinics' reputation grows.

3. The eminence of the clinicians would be an inducement for patients to attend these clinics.

4. Each part-time teacher would direct some of his patients to a University Clinic rather than his office, should this be necessary to maintain adequate numbers of patients.

The medical needs of the patient will determine the treatment given, otherwise the number of patients referred to the in-patient and out-patient University units and clinics would be governed by the beds available, the teaching needs of the moment, and the wishes of the chiefs of the services. The availability of beds in these units would be an important inducement to patient and doctor. The desire to retain his University affiliation would be a further inducement to each clinician to send patients to both his indoor and his outdoor units.

The Association sees neither the need nor the desirability for a closed, isolated University Hospital.

Section of General Practice

It is highly desirable that the Faculty of Medicine include general practitioners and that each teaching hospital has a General Practice Section. Many students indicate that practitioners who are members of the College of General Practice frequently offer them a high standard of instruction and experience.

In considering a Section of General Practice, the following quotation from the "Manual on General Practice Departments in Hospitals" issued by the College of General Practice in Canada, may be of interest:

> "These past thirty years have seen the practice of medicine developed to a high degree of specialization. This has led to increasing restrictions and limitations of the work done in hospitals. The Medical Associations of both Canada and the United States have recognized this paradox and have taken steps to correct this situation. Both the Canadian Council of Hospital Accreditation and the Accreditation Board of the American Hospital Association have passed resolutions recommending that the answer to the problem is the establishment of Departments of General Practice."

It is recommended that in the formation of General Practice Sections within the teaching departments, this manual be used as a basis for discussion, even though the Association may not subscribe to the entire content.

Section (c)

> "The Commission feels that the problems of undergraduate and graduate (residency) training present rather difficult problems and the Commission would like an expression of opinion on measures to ensure adequate training of residents."
>
> (Ref. — Commission letter 16 Nov. 60)

Undergraduates

The Manitoba Medical Association believes that the introduction of prepaid medical care as suggested in this Brief, should not affect undergraduate teaching.

Graduates

There need not be any effect on graduate teaching in non-procedural specialties, for example, internal medicine. There should be no difficulty in the assumption of graded responsibility for diagnosis and treatment by the Resident with the attending doctor in the supervisory background. Where procedures are to be carried out by the residents, the attending doctor would have to be in attendance and agree to the complete procedure being carried out by those for whose training he would be responsible. His criteria could be as follows:

1. The residents, in the judgment of the doctors directing the training, have reached a stage of competency adequate for the assumption of appropriate responsibility.

2. The resident should possess a licence to practise medicine in the Province of Manitoba.

3. The procedures which residents are carrying out are related to the requirements of the specific Resident-Training Program in which they are enrolled.

4. The patients for whose care they assume responsibility have given consent.

Many graduates desire an extra year of interneship prior to establishing a general practice. There should be provision for such rotating interneships in all the teaching hospitals. It is our opinion that the high stndards of general practice would be ensured were such training established.

Section (d)

> "In any extension of the 'Medicare' scheme the economics of payment for patient care will be important. The Commission would like to know the attitude of the Manitoba Medical Association

towards the payment of medical care given to patients on the teaching wards and out-patient departments of the teaching hospital."

(Ref. — Commission letter 16 Nov. 60).

The Economics of Payment for Patient Care in the Teaching Units

The Manitoba Medical Association adheres to the Canadian Medical Association's principle of fee-for-service. We would recommend that clinicians working in the in-patient teaching units and University clinics described above, be paid on a fee-for-service basis. Specific financial arrangements between these doctors and the University would be a matter for their decision. Many precedents already exist in Canada and the United States regarding both time and money arrangements between clinical teachers and their Universities. The Liaison Committee of the Manitoba Medical Association and the University, suggested elsewhere in this brief, might assist in solving any difficulties.

We have had several informal discussions with some members of the Board of the Manitoba Medical Service. We are confident that our suggestions are feasible. Patients attending either indoor teaching units or University clinics may be subscribers to the Manitoba Medical Service. Other patients may pay their own fees or be covered by commercial insurance. In effect, we foresee the cost of medical care given to patients in the University clinics would be paid for just as it is elsewhere. The University and the Medical teachers will make their own financial arrangements with consideration given to the cost of office space, staff and supplies as discussed above.

Payment for X-ray and Laboratory Services

The problem of paying for radiological and laboratory services has engaged our close attention. The Manitoba Medical Service would pay these costs for subscribers with comprehensive coverage, but it seems likely that the pattern of practice in the University Out-patient clinics might result in a far greater volume of ancillary services which would adversely affect the subscribers' premiums. Figures from both the Winnipeg General Hospital and St. Boniface Hospital shows increases each year in the use of X-ray for both In-patients and Out-patients. (Appen. 3 and 4). We suggest that we be guided by experiences in this problem. All ancillary services ordered in the way of clinical research would, we hope, be so labelled and paid for by research grants. If the "routine" ancillary services in the University Clinics far exceeded the experience elsewhere then various solutions based on accumulated experience can be discussed.

One solution might be that if the cost of ancillary services proved to be high, due to the demands of teaching, then the University might recognize its responsibility in this relationship, and make an appropriate contribution. We believe it would be necessary to collect one or two years data before a fair and wise arrangement could evolve.

Section (e)

"The Commission would appreciate an expression of opinion from the Manitoba Medical Association as to its responsibilities in the field of education of the future doctor."

(Ref. — Commission letter 16 Nov. 60)

We are of the opinion that we have a definite responsibility in the education of the future doctor. In addition, we have a very definite responsibility in the continuing education of all practising doctors in this province.

People will continue to demand the best in medical care. For all branches of medicine the foundation of quality is medical education. Anything that affects medical education affects medical research, affects medical practice and affects medical care. Therefore the problems of medical education are important not only to the Faculty but to all practising doctors. The Manitoba Medical Association believes that it must have a share in the responsibilities, the problems and challenges which this matter presents, and furthermore, believes that there must be a mechanism whereby this viewpoint can be expressed.

The Association is familiar with the problems of medical economics, which present a continually changing picture affecting medical education as the presence of this Commission proves.

In stating its proposals and agreeing to the establishment of University clinics in open competition with private practitioners for patient care, the Association understands that this implies the establishment of a Liaison Committee between the Faculty of Medicine and the Manitoba Medical Association. Through this committee, the Association shall expect a voice in the policies of medical education. The Association would be in a position to help in the solution of contentious matters which will undoubtedly arise as such policies change from time to time.

This special committee, whose function would be to investigate areas where differences exist between the Faculty of Medicine and the Manitoba Medical Association would:

1. Assure the continuation of liaison between these two bodies.
2. See to it that all data and facts are made available to all concerned, and,
3. Seek to resolve differences of opinion.

The doctors of Manitoba are responsible for placing in office the members of the College of Physicians and Surgeons. The College of Physicians and Surgeons is responsible for the licensing of doctors in this province. Therefore the interest and responsibility of the doctors of Manitoba in medical education is unquestionable.

The Association strongly believes that in establishing and maintaining high standards of medical education, continued attention must be given to the

adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education.

Education of the Future Doctor

Regarding education of the future doctor, the Association pays tribute to the high quality of instruction in both the basic and clinical sciences. However, there appears to be a definite lack of training in the "art" of medical practice — that indefinable intimate personal relationship between doctor and patient, which must be learned but which is so difficult to teach. In this connection the use of "family care" programs and especially of preceptorship training appears to be necessary.

Preceptorships have been used in the Faculty of Medicine but on a rather loosely organized basis. Two other professions, Law and Accountancy, use a form of organized preceptorship with excellent results. We envisage a well organized preceptorship program under the direct supervision of a faculty member, with the preceptors a distinct part of the part-time medical faculty. They would be paid for their teaching time and would be responsible for their performance. It might also be wise to arrange from time to time short courses for these preceptors to make sure they are in step with all the recent advances in medical practice. The University of Wisconsin after thirty years' experience with preceptorships states:

"As reported the students are enthusiastic over the program and apparently look forward to it as one of the high points of their medical school career. The students who spend twelve weeks out of the 48 week senior year in this program express the belief that this allocation of time for the preceptorship should not be reduced. Those students who have completed the experience indicate that its greatest benefit was the opportunity to see acute disease problems which they do not encounter frequently at the University Hospital. They also find that their patient relationships are more intimate, penetrating and more satisfactory, as they make the initial contact with them rather than after the various preliminary procedures involved with the patients at the teaching hospitals. They have more opportunity to see the patient's family and to understand the total problem as well as to learn how more effectively to talk with patients. The experience with the preceptor sometimes helps to determine the field of medicine that the student decides he does not wish to enter as well as suggesting a possible major field of interest."

In summarizing the alumni attitudes towards this thirty-year program they found "that those that look back on their participation as part of medical education were very enthusiastic. It was considered to afford a close teacher-student relationship that had been of genuine value."

Our own recent graduates who have gone into General Practice, many of them after a second year of interneship, tell us that the present course, although excellent scientifically, does not prepare them for the non-scienific problems of every day practice.

We, therefore, strongly recommend the establishment of a preceptorship program on an organized basis at the Faculty of Medicine, University of Manitoba.

We would also suggest a family-care program. By that we mean a student is assigned to a family through the co-operation of the Out-Patient Department (University Clinics) and the Social Welfare Agencies of the Teaching Hospitals. Education in socio-economic backgrounds and how they affect health can thus be developed. As family-care programs are further developed, undergraduate students could engage in these for the purpose of viewing social and economic backgrounds.

With these recommendations we merely emphasize the importance of transmitting some experience in the art of the practice of medicine as well as the science.

The Manitoba Medical Association has already paid tribute to the present high standard of education by the Faculty of Medicine. We feel, however, many of us being part-time teachers, that not enough attention is paid to educational principles and techniques. These change as the volume of accumulated medical knowledge changes and grows. At the Medical School of Western Reserve University in Cleveland, a few years ago, evaluation studies of their teaching methods were instituted. Their studies have shown that research in medical education appears to be as greatly needed as in other fields of endeavor.

This conclusion appears sound to us and we would urge very close liaison with the Faculty of Education of the University including regular seminars by that faculty for those engaged in medical education, particularly for the part-time teachers.

The Practising Doctor

The continuing education of the practising doctor is of direct concern to the profession. In previous years the Faculty of Medicine had established refresher courses for periods of a week's duration. These were very popular and well attended. Unfortunately these courses were discontinued without consultation with the Medical Association, and we now find that the rural doctors particularly are concerned about this discontinuance. We would therefore urge:

1. The continuation of week-long refresher courses.

2. The encouragement of more papers to District Medical Societies which both the Association and the Faculty of Medicine have co-operated in for years.

3. The co-operation as much as possible of Faculty

members in the meetings and courses which are mutually set up.

The Recruitment of Medical Students

The Manitoba Medical Association feels that the reduction in the number of those enrolled in the Faculty of Medicine is a matter for study by the University, the Government, the Manitoba Medical Association and the College of Physicians and Surgeons.

The basis for this reduction, universal in scope, defies accurate analysis. However, since the medical course is the most lengthy and most expensive of all the careers offered by the University, the study of financial aids to students in this area is desirable.

Our opinion is that at present, the scholarships and bursaries available are inadequate and the various loan funds available are surrounded by too many restrictions. The matter of internes' and residents' salaries is a subject for discussion by the Liaison Committee. The Association is prepared to offer its co-operation in any attempt to solve these problems. We might emphasize that the practising doctor is a potent force in the recruitment of medical students.

Recommendations

The following are the summarized recommendations of the Manitoba Medical Association under the particular terms of reference for which comments were requested by the Commission in its letter of 16th November, 1960.

(a)

1. "Medicare" with its present limited prepaid coverage is unsatisfactory to both patient and doctor.

2. The Association recommends that "Medicare" be expanded to give complete comprehensive coverage to the indigent and also extended to the para-indigent (marginal income) group in Manitoba. Identification of these groups should be a matter for discussion and agreement between the Provincial Government and the Manitoba Medical Association.

(b)

1. The Association recommends the establishment of teaching units in the hospitals designated by and under the direction of the Faculty of Medicine, University of Manitoba.

2. The Association recommends the establishment of university clinics instead of the present out-patient departments, under the direction of the Faculty of Medicine, University of Manitoba.

3. The Association recommends the inclusion of a General Practice Section as part of each Teaching Hospital Staff.

(c)

1. The Association believes that it is possible to train both undergraduate and postgraduate students having only private patients as a source for clinical teaching.

2. The Association recommends the continuation of residency programs in all fields.

(d)

1. The Association recommends a "fee-for-service" arrangement between patient and doctor in the university clinics and teaching units. The financial arrangement between the doctor and the University should be a matter of individual and separate negotiation.

2. The Association recommends that comprehensive medical care coverage should be provided by the non-profit Manitoba Medical Service, the payment for such coverage to be a matter for negotiation by the Provincial Government, the Manitoba Medical Association and the Manitoba Medical Service.

(e)

1. The Association recommends the establishment of a Liaison Committee between the Manitoba Medical Association and the Faculty of Medicine, University of Manitoba.

2. The Association recommends the study of educational principles and techniques, especially by the part-time teachers, in co-operation with the Faculty of Education, University of Manitoba.

3. The Association recommends the development of teaching programs which closely involve each student in the health problems of a family.

4. The Association recommends the institution of a preceptorship program for undergraduate students in the final academic year.

5. The Association recommends a periodic formal study of medical education in view of the changing picture in medical science and in medical economics. This should be a joint effort of the University through its Faculty of Medicine, the College of Physicians and Surgeons and the Manitoba Medical Association.

The ultimate solution of the problems presented to medical education by the extension of tax-supported prepaid medical care to those unable to pay may be more difficult than we have foreseen. Therefore the Manitoba Medical Association feels that it should be consulted by the Provincial Government regarding each new development in this field.

We must again emphasize the necessity for establishing an active Liaison Committee between the Faculty of Medicine, University of Manitoba, and the Manitoba Medical Association. Through this committee we can study and assess new developments as they occur.

All of which is respectfully submitted.

Manitoba Medical Association

H. L. McNicol, M.D.,
President.

M. T. Macfarland, M.D.,
Executive Director.

Appendix 1

The Association acknowledges the assistance given by the following Members, Sections and District Societies:

Members: A. H. Bartley, W. G. Brock, R. A. Christie, R. F. Clark, L. R. Coke, A. D. J. DePape, V. Dick, F. D. Doyle, J. F. Edward, Roy Giles, L. J. Gregory, G. Heinisch, A. M. Holm, J. L. Honig, J. E. Hudson, S. Jauvoish, L. V. Jonat, G. E. Mosher, M. Newman, D. Parkinson, R. M. Ramsay, John N. R. Scatliff, C. M. Thomas, A. P. Warkentin.

Sections: Section of Anaesthesia; Eye, Ear, Nose and Throat Section; Section of General Practice; Section of Obstetrics and Gynaecology; Orthopaedic Section; Section of Pathology; Section of Paediatrics; Section of Psychiatry.

District Medical Societies: Brandon and District Medical Society, Northern District Medical Society, North of 53 District Medical Society, Northwestern District Medical Society, College of General Practice, (Manitoba Chapter).

Appendix 2
The Canadian Medical Association's Statement on Medical Services Insurance
June, 1960

The Canadian Medical Association believes that:

The highest standard of medical services should be available to every resident of Canada.

Insurance to prepay the costs of medical services should be available to all regardless of age, state of health or financial status.

Certain individuals require assistance to pay medical services insurance costs.

The efforts of organized medicine, governments and all other interested bodies should be co-ordinated towards these ends.

While there are certain aspects of medical services in which tax-supported programs are necessary, a tax-supported comprehensive program compulsory for all, is neither necessary nor desirable.

The Canadian Medical Association will support any program of medical services insurance which adheres to the following principles:

1. That all persons rendering services are legally qualified physicians and surgeons.

2. That every resident of Canada is free to select his doctor and that each doctor is free to choose his patients.

3. That the competence and ability of any doctor is determined only by professional self-government.

4. That within his competence, each physician has the privilege to treat his patients in and out of hospital.

5. That each individual physician is free to select the type and location of his practice.

6. That each patient has the right to have all information pertaining to his medical condition kept confidential except where the public interest is paramount.

7. That the duty of the physician to his individual patient takes precedence over his obligation to any medical services insurance programs.

8. That every resident of Canada, whether a recipient or provider of services, has the right of recourse to the courts in all disputes.

9. That medical services insurance programs do not in any way preclude the private practice of medicine.

10. That medical research, undergraduate and postgraduate teaching are not inhibited by any medical services insurance program.

11. That the administration and finances of medical service insurance programs are completely separate from other programs, and that any board, commission or agency set up to administer any medical services insurance program has fiscal authority and autonomy.

12. That the composite opinion of the appropriate body of the medical profession is considered and the medical profession adequately represented on any board, commission or agency set up to plan, to establish policy or to direct administration for any medical services insurance program.

13. That members of the medical profession, as the providers of medical services, have the right to determine the method of their remuneration.

14. That the amount of remuneration is a matter for negotiation between the physician and his patient, or those acting on their behalf; and that all medical services programs make provision for periodic or automatic changes in remuneration to reflect changes in economic conditions.

Appendix 3
Winnipeg General Hospital
Diagnostic Radiology

Year	In Patients	O.P.D.	Private O.P.D.	Total	Percent of Examinations Over Patients
1956					
Patients	— not segregated —			21,901	12.8%
Examinations				24,708	
1957					
Patients	15,151	7,691		22,842	12.4%
Examinations				25,695	
1958					
Patients	16,628	9,165		25,793	14.9%
Examinations				29,581	
1959					
Patients	18,758	10,305		29,063	18.8%
Examinations				34,525	
1960					
Patients	20,357	11,623		31,980	19.9%
Examinations				38,245	

The examinations of indoor and O.P.D. patients have never been segregated and these figures are not available.

The total number of patients examined has increased 46% since 1956.

The total number of examinations has increased 54% since 1956.

Appendix 4
St. Boniface Hospital
Diagnostic Radiology

Year	In Patients	O.P.D.	Private O.P.D.	Total	Percent of Examinations Over Patients
1956					
Patients	14,977	1,462	1,241	17,680	28%
Examinations	19,187	1,940	1,640	22,767	
1957					
Patients	17,711	1,673	1,922	21,306	34%
Examinations	23,738	2,223	2,600	28,561	
1958					
Patients	18,294	2,062	3,818	24,174	36.1%
Examinations	24,785	2,949	5,169	32,903	
1959					
Patients	19,792	2,484	4,505	26,781	33.3%
Examinations	26,546	3,552	5,624	35,722	
1960					
Patients	21,175	2,479	4,842	28,496	24%
Examinations	25,385	3,842	6,120	35,347	

The total number of patients examined has increased 61.12% since 1956.

The total number of examinations has increased 55.26% since 1956.

Winnipeg Medical Society Committee Reports 1960 - 1961

Report of the Secretary

To the President and Members of
The Winnipeg Medical Society:

Regular monthly meetings of the Council of the Society were begun September 12th, 1960, under the chairmanship of Dr. R. L. Cooke. Several general meetings were held during the year, and we were fortunate in having excellent local and visiting speakers at their meetings during the year.

During the past year, the Society lost through death, the following members: Dr. J. A. Gunn, Dr. E. G. Hollenberg, Dr. J. P. Gussin, Dr. W. F. Tisdale, Dr. E. H. Whelpley, Dr. Jack Brenner, Dr. W. C. Handford, and Dr. G. Novak.

Our thanks to Dr. M. T. Macfarland and his staff for the assistance given us during the year.

Respectfully submitted.

T. W. Fyles,
Secretary.

Auditor's Report

Treasurer

April 5, 1961.

To the Members,
The Winnipeg Medical Society,

Winnipeg, Manitoba.

In accordance with your instructions we have examined the accounts of

THE WINNIPEG MEDICAL SOCIETY

— and —

THE WINNIPEG MEDICAL SOCIETY LIBRARY FUND

for the eleven months ended March 31, 1961, and have prepared therefrom and submit herewith the following financial statements for your consideration:

Exhibit A Balance Sheet, as at March 31, 1961,

Exhibit B Statement of Revenue and Expenditure.

We report thereon as follows:

Balance Sheet

Cash on Hand and in Bank:

Cash on hand was verified by actual count as at date of audit. Cash on deposit in General and Library Fund Accounts was verified by correspondence direct with The Toronto-Dominion Bank, Portage and Edmonton Street Branch, Winnipeg.

Membership Fees Receivable:

This item represents membership fees unpaid as at March 31, 1961, as shown by the records of the Society, as follows:

1959-60 Membership Fees	$ 30.00
1960-61 Membership Fees	120.00
	$150.00

The unpaid balances have not been verified by correspondence with the members concerned.

Grant Receivable — General Fund:

This item represents an additional grant authorized in minutes of Council from the General Fund for the fiscal period ended March 31, 1961 and not received by that date.

Bond Interest Receivable:

At the date of this Report the cheque for bond interest has been received and deposited in the Society's bank account.

Investments in Bonds:

The investments of the Society as at March 31, 1961, were as follows:

	Cost	Par Value	Approximate Market Value
Government of Canada:			
3¾% due 1978	$1,473.75	$1,500.00	$1,256.25
3¼% due 1979	1,003.75	1,000.00	772.50
4½% due 1983	3,031.88	3,000.00	2,692.50
The Hydro Electric Power Commission of Ontario:			
5% due 1976	1,005.00	1,000.00	965.00
	$6,514.38	$6,500.00	$5,686.25

All of the foregoing investments, held in a safety deposit box in The Toronto-Dominion Bank, were produced for our examination and, in all cases, were fully registered in the name of The Winnipeg Medical Society.

Accounts Payable:

Reasonable care was exercised by us to insure that the attached Balance Sheet properly reflects all known liabilities of the Society as at March 31, 1961.

Grant Payable — Library Fund:

This item represents an additional grant authorized in minutes of Council for the fiscal period ended March 31, 1961, and unpaid at that date.

Membership Fees Paid in Advance:

This item represents 1961-62 membership fees received prior to March 31, 1961.

Statement of Revenue and Expenditure

The operations of the Society for the eleven months ended March 31, 1961, resulted in a net revenue of $313.55 on the General Fund Account and net expenditure of $199.66 on Library Fund Account. Full details are set forth on Exhibit B attached.

Revenue from membership fees is in accordance with your records, supported by duplicate receipts which were examined by us. Interest on bonds has been fully accounted for.

All expenditures for the fiscal period have been approved in minutes of Council, and adequate vouchers were examined by us in support thereof.

General

At the Annual Meeting of the Society held May 13, 1960, the By-laws of the Society were amended to change the fiscal year-end of the Society from April 30 to March 31.

* * *

We record with pleasure our appreciation of the courtesies and co-operation extended to us by Council members and staff during the course of our examination. Should any further information or explanations be required in connection with the attached accounts we shall be glad to be of service.

Auditors' Certificate

We have examined the balance sheets of The Winnipeg Medical Society and The Winnipeg Medical Society Library Fund as at March 31, 1961, together with the related statements of revenue and expenditure for the fiscal period ended that date, and have obtained all the information and explanations we have required.

In our opinion, the attached balance sheets and statements of revenue and expenditure are properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Society as at March 31, 1961, and the results of its operations for the fiscal period then ended, according to the best of our information and the explanations given to us and as shown by the books of the Society.

Yours faithfully,
Sill, Streuber, Meger & Fiske,
Chartered Accountants.

EXHIBIT A

Balance Sheet
As at March 31, 1961

ASSETS

	General Fund	Library Fund
Cash on Hand and in Bank	$ 3,581.98	$2,721.78
Membership Fees Receivable	150.00	
Grant Receivable — General Fund		250.00
Bond Interest Receivable	16.25	
Investments — at cost:		
Government of Canada Bonds	5,509.38	
Hydro-Electric Power Commission of Ontario Bond	1,005.00	
	$10,262.61	$2,971.78

LIABILITIES

Accounts Payable	$ 145.04	$ 115.80
Grant Payable — Library Fund	250.00	
Membership Fees Paid in Advance	19.00	
	$ 414.04	$ 115.80
SURPLUS:		
Balances as at May 1, 1960	$ 9,535.02	$3,055.64
Net Revenue *Expenditure* for eleven months ended March 31, 1961 (Exhibit B)	313.55	*199.66*
Balance as at March 31, 1961	$ 9,848.57	$2,855.98
	$10,262.61	$2,971.78

EXHIBIT B

Statement of Revenue and Expenditure
For eleven months ended March 31, 1961
General Fund

Revenue:		
Membership Fees:		
Active Members	$4,072.00	
Non-resident and Associates	8.00	$4,080.00
Bond Interest		273.74
		$4,353.74
Expenditure:		
Audit Fees	75.00	
Bank Charges, including Safety Deposit Box Rental	5.90	
Catering Expense	336.55	
Donations — Sundry	12.00	
Grants:		
Library Fund	1,250.00	
Rotary Club for Science Fair	50.00	
General Expenses	38.29	
Lantern Slides and Expense	60.00	
Manitoba Medical Association — Share of office salaries and expense	1,210.00	
Printing, Postage and Stationery	890.90	
Speaker's Expenses	111.55	$4,040.19
Net Revenue for eleven months ended March 31, 1961 (Exhibit A)		$ 313.55

Library Fund

Revenue:		
Bank Interest	$ 25.27	
Grants — General Fund	1,250.00	$1,275.27
Expenditure:		
Books and Periodicals Purchased	1,378.93	
Library Supervision	96.00	1,474.93
Net *Expenditure* for eleven months ended March 31, 1961 (Exhibit A)		*$ 199.66*

Community Chest

To the President and Members of
The Winnipeg Medical Society:

The Community Chest Campaign for 1960 was a complete success. Our quota was raised by approximately 10% but throughout the campaign the doctors remained in eighth or ninth place out of twenty-five divisions and over-subscribed the quota.

The method of compaigning, namely by personal letter to the doctors, seems to be well accepted by the profession and I recommend that this system be maintained. I also recommend that the representative of The Winnipeg Medical Society keep a firm control on the letters that are sent to the profession so that some of the problems that have come up in the past are avoided.

Respectfully submitted.

James R. Mitchell,
Chairman.

Library

To the President and Members of
The Winnipeg Medical Society:

The statistical information appended is provided by the Librarian, Mrs. Philpott, showing expenditures from our account. The Library Committee expects in future to have a budget for Special Accounts such as ours. This will be a new departure. It is anticipated that more emphasis will be placed on the purchase of periodicals. In February the Council made a special extra grant of $250.00 to the Library Fund. This means that for the year 1960-61 each paid-up member contributed more than three dollars to the Library.

EXPENDITURES	1959-1960	1960-1961
Books	$ 300.00	$ 700.00
Binding	1,000.00	1,100.00
Evening hours	236.00	236.00
	$1,536.00	$2,035.00
BOOK DISPLAYS		
Before meetings of the Society	5	4
BORROWERS		
Library users	321	338
Items borrowed	12,206	14,979
MEDICAL LIBRARY COMMITTEE MEETINGS	2	3

Respectfully submitted.

Murray H. Campbell,
Representative.

Membership

To the President and Members of
The Winnipeg Medical Society:

Membership in the Society is as follows:

Active paid-up members	372	
Active paid-up members (half rate)	43	
Associate or Non-resident members	4	
Total paid-up members		419
Life Memberships	33	
Free membership (over 65)	33	
Non-active	9	
		75
Membership fees unpaid		13
		507

During the past year eight members were lost to the Society through death and four have moved from this area. Five members resigned.

Respectfully submitted.

John A. Swan,
Chairman.

Legislative Committee

To the President and Members of
The Winnipeg Medical Society:

During the past year no matters have been considered by the committee and no meetings have been held.

Respectfully submitted.

A. B. Houston,
Chairman.

Program

To the President and Members of
The Winnipeg Medical Society:

During the year 1960-61, the following meetings of the Winnipeg Medical Society were held. The titles and speakers were as follows:

Sept. 16, 1960:
"A Physician in Morocco"
Dr. M. H. L. Desmarais, Winnipeg.

Oct. 25, 1960:
"A Plastic Surgeon in India"
Sr. Major (Dr.) H. Williams, London, England.

Nov. 18, 1960:
"Hernia"
Dr. C. B. McVay, University of South Dakota.

Dec. 16, 1960:
"A Pathologist in the Caribbean"
Dr. J. M. Ridge, Winnipeg.

Jan. 20, 1961:
"A Radiotherapist in Burma"
Dr. J. E. Bennett, Winnipeg.

Feb. 17, 1961:
"Diabetes and the Kidney"
Dr. D. Gellman, Winnipeg.
"Vascular Purpura"
Dr. A. Zipursky, Winnipeg.

March 23, 1961:
"The Virus in Respiratory Diseases"
Professor T. Anderson, Glasgow.
This meeting was held in conjunction with that of the Canadian Thoracic Society.

I would like to express my particular thanks to Mrs. M. McBride, permanent secretary of the Winnipeg Society, for her assistance in the preparation of the program.

Respectfully submitted.

C. Jean McFarlane,
Chairman.

Public Health

To the President and Members of
The Winnipeg Medical Society:

As there were no meetings of the Standing Committee on Public Health of the Winnipeg Medical Society, there is nothing to report.

Respectfully submitted.

J. B. Morison,
Chairman.

Public Relations

To the President and Members of
The Winnipeg Medical Society:

Since assuming office in mid-term your public relations officer has had no momentous decisions to make. He has attended meetings of the Public Relations Committee of the Manitoba Medical Association as a representative of your society and can assure members that great strides are being made to portray the medical profession to the general public.

Respectfully submitted.

M. J. Lehmann,
Chairman

Trustees

To the President and Members of
The Winnipeg Medical Society:

As Trustee, I wish to report the following securities as being held in the Safety Deposit Box, Toronto-Dominion Bank, 394 Portage Avenue, as inspected by Dr. R. L. Cooke and Dr. J. W. Whiteford.

Three Government of Canada Bonds, 4½% maturing 1983 — each $1,000.00	$3,000.00
Three Government of Canada Bonds, 3½% maturing 1978 — each $500.00	1,500.00
One Government of Canada Bond, 3½% maturing 1979 — at $1,000.00	1,000.00
One Hydro Electric Power Commission of Ontario Bond, 5% maturing 1976 — at $1,000.00	1,000.00
Total	$6,500.00

Respectfully submitted.

James W. Whiteford,
Trustee.
Robert Leighton Cooke,
President.

Welfare Council

To the President and Members of
The Winnipeg Medical Society:

Your representative continued to act as chairman of the Health Division, Welfare Council of Greater Winnipeg through 1960 to February, 1961. The 1956-1961 program of the Division was a series of presentations to acquaint member agencies with treatment and services available in Greater Winnipeg area for children and adults requiring emotional and psychiatric assistance. This series was well received with an average attendance of something over sixty persons.

The Health Division Welfare Council assisted the Extension Department, University of Manitoba, in presenting an Institute on Medical Social Service work in February, 1961. This Institute was very well attended by Medical Social Service workers and individuals working in allied fields particularly concerned with rehabilitation of sick and injured people.

Respectfully submitted.

P. K. Tisdale,
Representative.

Anaesthesia

To the President and Members of
The Winnipeg Medical Society:

I take pleasure in submitting this report on the activities of the Winnipeg Anaesthetists' Society for 1960-61:

June, 1960:
The Professional Planning Committee met to discuss further the fees for the anaesthetic bloc. A letter was sent to Dr. K. R. Trueman, Chairman of the Fee Economics Committee of the Manitoba Medical Association. Copies of this letter went out to Dr. H. Malcolmson, Chairman of the Professional Policy Committee, and Dr. M. T. Macfarland, Executive Secretary.
The program for 1960-61 was drawn up.
The Western Division, Canadian Anaesthetists' Society, Annual Meeting for March, 1961, was discussed and its planning was commenced.

July, 1960:
The Executive met with Mr. G. B. Rosenfeld at Victoria General Hospital to plan and arrange for the October dinner meeting to be held at the banquet room of the Nurses' Residence at that hospital, and to plan on Dr. M. Sadove as guest speaker.
The Executive met to discuss further and plan for the March, 1961, Annual Convention.

August, 1960:
The Planning Committee met to discuss a program for the Western Convention, and arrange for speakers.

September, 1960:

A reception and smorgasbord was held at the Club Morocco, so that the members of the Society could meet with anaesthetists on the post-Convention tour No. 3 of the 2nd World Congress of Anaesthetists.

A dinner meeting with Dr. M. Sadove as our guest speaker was held at the Nurses' Residence of the Victoria General Hospital.

October, 1960:

The Planning Committee held another meeting to discuss and plan for the Western Convention. It was agreed to hold it at the Medical College Auditorium on March 9th, 10th and 11th, 1961.

November, 1960:

The regular monthly meeting was held at the Medical Arts Club Rooms.

The members were brought up to date on the place, time, speakers and related items for our Western Division March Convention.

"Medicare" was mentioned.

The scientific part of the meeting included a talk "Emphysema in the Aged" by Dr. Strawbridge, pathologist at the Winnipeg General Hospital; and talk on "Cardiac Arrest" by Drs. D. Huggins, Ross, Madalosso and Wolkenstein, with a presentation of two case histories. A discussion followed.

December, 1960:

Our Annual Dinner and Dance was held this year at Vasalund. A very successful evening was enjoyed by all.

January, 1961:

The January meeting was held as usual.

The program for the coming convention was read and discussed.

"Medicare" was discussed in length and a brief was sent to the Commission on Medical Education in the Province of Manitoba.

The scientific portion of the meeting was composed of a presentation by St. Boniface and Children's Hospitals. Drs. Semelka and Lambie gave an interesting talk on "Epidural Anaesthesia," with slides. A discussion followed. Drs. McCaughey, Holm and Lertzman gave a talk on "Resuscitation at Children's Hospital and the value of the Respiratory Unit," with a case presentation and slides. A discussion followed.

The planning committee met to draw up the March Convention program, to discuss a visit by Dr. Holmdahl, and to discuss "Medicare."

February, 1961:

The Relative Fee Schedule was brought up and discussed. It was mentioned that its implementation was long overdue.

The draft copy of the proposed regulations under the Hospital Act and relating to standards for Licensure as related to anaesthetists and the Anaesthetic Department was discussed.

The scientific part of the meeting was given by Dr. R. Lambie on "Anaesthesia and Surgery on the patient who is a Jehovah's Witness." A discussion followed.

This Society invited Dr. Martyn Holmdahl from the United States and Sweden to sivit us February 19th to 21st. He gave us several interesting talks, including "Experiences with an intensive Respiratory Care Unit," and "Extra Corporeal Circulation and Hypothermia as related to Anaesthesia."

March, 1961:

The Canadian Anaesthetists' Society (Western Division) Annual Meeting was held in Winnipeg, March 8th to 11th inclusive, with the Manitoba Division as hosts for the convention. A very fine program was presented scientifically as well as socially. Amongst the scientific participants were: Dr. Solomon G. Hershey, Director of Anaesthesia at Beth Israel Hospital of New York, and Dr. Louis R. Orkin, Professor and Chairman, Albert Einstein College of Medicine, Yeshiva University of New York.

The theme of the scientific sessions was "Shock" and "Pulmonary Function and Disease and Anaesthesia."

April, 1961:

Nominations and election of officers for the ensuing year will take place, and a review and presentation of interesting cases by members from various hospitals.

May, 1961:

A Dinner Meeting with a guest speaker will take place at the Club Rooms, being our final meeting for this session.

Respectfully submitted.

Arnold W. Holm,
Secretary-Treasurer.

Internists' Section

To the President and Members of
The Winnipeg Medical Society:

During the academic year 1960-61, Internists' Section heard a paper by Dr. W. S. Stanbury of the University of Manchester entitled "Renal Osteodystrophy."

Further scientific meetings are planned at the time of submission of this report.

A new slate of officers will be elected in the near future.

Respectfully submitted.

M. F. McInnes,
Chairman.

Medical History

To the President and Members of
The Winnipeg Medical Society:

Only one meeting has been held of this Society this year.

Dr. Athol Gordon spoke on "The Coroner — Past and Present," a most entertaining and instructive evening enjoyed by all those present.

Dr. L. A. Sigurdson has been re-elected President of the Society.

It should be remembered that all members of the Winnipeg Medical Society are automatically members of the Historical Society without additional dues, and all are welcome at these very enjoyable and informative meetings.

Respectfully submitted.

Dwight Parkinson,
Secretary.

Radiology

To the President and Members of
The Winnipeg Medical Society:

Reference your letter in regard to a report of the Section on Radiology to be submitted to the President and Members of The Winnipeg Medical Society.

The report is as follows: During the year the Section of Radiology met on two occasions to discuss matters of current interest.

Respectfully submitted.

J. B. Squire,
Secretary.

Manitoba Medical Review

To the President and Members of
The Winnipeg Medical Society:

As representative of your Society to the Manitoba Medical Review, I have made no useful contribution during the past year. I would suggest that the position and duties be defined more clearly. If it is felt that the representative has nothing to offer, then the position should be discontinued.

Respectfully submitted.

J. P. Maclean,
Representative.

Obstetrics and Gynaecology

To the President and Members of
The Winnipeg Medical Society:

Six meetings of the section were held in the past year. Three were dinner meetings. The following papers were presented at scientific sessions:

1. Mr. V. B. Green-Armytage — Surgical and Medical Treatment of Tubal Occlusion.
2. Dr. Elinor Black — Fantasies of the Future in Obstetrics and Gynaecology.

3. Dr. A. A. Earn — What is the Vacuum-Extractor.

The following distinguished guests were present at a dinner meeting in the Marlborough Hotel:

Mr. V. B. Green-Armytage of the Postgraduate Medical School, London, England.

Professor Bernhard Zondeck of the Hebrew University Medical School, Jerusalem, Israel.

Dr. L. Ayers, Emeritus Professor of Surgery, New York University, N.Y.

Major business sessions dealt with the following:

1. Draft of Fee Relative Value Index.
2. Canadian Cytology Committee request for information.
3. Brief to Economics Committee, MMA re inquiry by Government Commission into Medical Education.
4. Report of the First National Conference Committee on Maternal Welfare.
5. Brief to ad hoc Committee MMA re: Draft of Proposed Regulations under the Hospitals Act (Manitoba).

Attendance at all meetings continues to be good to excellent.

Respectfully submitted.

A. A. Earn,
Secretary.

Paediatrics

To the President and Members of
The Winnipeg Medical Society:

The Paediatric Section held several dinner meetings throughout the 1960-61 season at which the following visiting speakers gave interesting talks:

Dr. John Millichap, Minneapolis.
Dr. John Lorberg, Sheffield.
Dr. Charles Janeway, Boston.

Respectfully submitted.

K. O. Wylie,
Chairman.

Manitoba Medical Association

To the President and Members of
The Winnipeg Medical Society:

As representatives to the Executive Committee of the Manitoba Medical Association Dr. MacDougall and I have attended the regular meetings and reported all pertinent information back to the Council.

Respectfully submitted.

Robert Cooke,
President.

Election Results — 1961-62

President: Dr. J. T. MacDougall
Vice-President: Dr. M. H. Campbell
Secretary: Dr. J. R. Mitchell
Treasurer: Dr. C. J. McFarlane
Trustee: Dr. J. A. Swan.

Social News

Reported by K. Borthwick-Leslie, M.D.

Congratulations to Dr. J. A. MacDonnell, chief consultant of medicine for the Municipal Hospitals and director of the Chest Division, Deer Lodge Hospital, on being awarded the $500.00 geriatric study fellowship by the National Council of Jewish Women.

☆

Also, Dr. Max Desmarais, director of physical medicine in the Municipal Hospitals and University of Manitoba, who has been honored by the Canadian Red Cross Society for his excellent work as director of rehabilitation of 10,000 toxic paralysis cases in Morocco in 1960.

☆

Also, Dr. Athol Gordon, who so ably represents our profession in the Arts. His oil painting "Attic Corner" recently received much favorable comment at the Art Display of local talent at the Hudson's Bay. Nice work, Athol.

☆

Then of course we "made" T.V. last month too. Dr. Maxwell made his debut in public on the "Eye to Eye" program. His subject of discussion, though rather unfortunate, was well put over, but has not increased his popularity with the ladies any. Quote from the Tribune: "Dear Miss Henry — Please tell the guys on that "Eye to Eye" panel that nobody wants to marry them anyway. Tell them Canadian girls aren't interested in them or their opinions, who do they think they are anyway."

Too bad, boys, looks as though you might have to go back home to find your right type of joyous housekeeper.

☆

Dr. Alan Parkin, an honors graduate and gold medalist from the U. of M., now assistant professor in psychiatry, University of Toronto, will be one of the speakers during the Third World Congress of Psychiatry in Montreal, June 4th to 10th.

☆

Overheard on Radio News yesterday and not confirmed yet that our friend Dr. Wendell McLeod is resigning as Dean of Medicine, University of Saskatchewan.

☆

The Manitoba Clinic announces the establishment of its Department of Plastic and Reconstructive Surgery under the direction of Dr. Desmond A. Kernohan, M.B., F.R.C.S.(Ed.), recently consultant plastic surgeon to the Liverpool Regional Hospital Board, England.

☆

May 24th — at the home of Dr. Emma Adamson, South Drive, Fort Garry, the Manitoba Branch of the Federation of Medical Women of Canada, held the annual reception and buffet supper honoring our 1961 Medical Women Graduates, i.e., Doctors Dawna Duncan, Beryl Rathjen, Helen Toews, Dorothy Bednar and Maia Kaarsoo.

☆

We members-at-large, including myself, are to be severely reprimanded for the very poor showing we made in attendance. We are going to have to bestir ourselves and get behind the new executive if we are to prepare for the C.M.A. Meeting here in 1962.

The executive is:

President Elect — Dr. Dorothy Barnhouse
President — Dr. Donna Semelka
Vice-President — Dr. Emma Adamson
Past President — Dr. Marie Storrie
Treasurer — Dr. Aldis Wengel
Assistant Treasurer — Dr. Margaret Loewen
Secretary — Dr. Katrina Nagy
Assistant Secretary — Dr. Margaret Forke.

☆

A new feature this year was the presentation to the graduates of a beautiful hand made original design pin, much appreciated by the girls. This pin may be obtained by ordering through Dr. Semelka and will be a mark of distinction for all our members. They are really a beautiful product and conversational piece.

☆

Dr. Emma Adamson and Dr. Donna Semelka are taking off for the C.M.A. meeting in Montreal June 24th to represent our Manitoba Branch.

☆

Dr. and Mrs. L. R. Mackey announce the engagement of Andrea Gail to Mr. John Dale Anderson, the wedding to take place June 24th.

☆

Mr. and Mrs. Max Morganstern announce the engagement of their youngest daughter, Eleanor Margaret, to Dr. Jerome Philip Mednick. The wedding to be June 22nd.

☆

Mr. and Mrs. Robert Lyons announce the engagement of Margaret Anne to Dr. William Gordon Langton Carr. The wedding will take place June 17th.

☆

Dr. and Mrs. Thomas A. Lebbetter are pleased to announce the birth of Ann Elizabeth, baby sister for Catherine, at the Royal Victoria Hospital, May 9th, 1961.

☆

Dr. and Mrs. Gordon Minty, Calgary, Alta., announce the arrival of their third child, John Burns, on April 24th, 1961.

☆

Dr. and Mrs. Jack Ledger are pleased to announce the birth of Deborah Elizabeth, May 18th, 1961.

☆

Dr. and Mrs. K. N. Walton announce the birth of Gary Richard, baby brother for Keith, May 23rd, 1961.

☆

Dr. and Mrs. A. L. M. Davidson proudly announce the arrival of their first born, Sandra Elizabeth, May 28th, 1961.

☆

Dr. and Mrs. J. F. Choate, Steinbach, Manitoba, are pleased to announce the birth of a son, Robert Charles, a brother for Catherine and Gordon, May 30th, 1961.

PHOTO BY: ASHLEY AND CRIPPEN

Canadian Mental Health Research Fund Director Named

J. S. D. Tory, Q.C., national president of the Canadian Mental Health Association, announced that Dr. Ray F. Farquharson will be honorary director of the association's research fund.

The fund, financed by voluntary donations to mental health campaigns, was established by the association to ensure continuing research in mental health and illness. Single grants up to $25,000 are awarded to encourage scientists to make a career of mental health research. These are among the largest scientific grants now offered in Canada.

Dr. Farquharson, professor emeritus of the University of Toronto Medical School, is also chairman of the Medical Research Council of Canada which was created last November. He has been physician-in-chief at the Toronto General Hospital, president of the Royal College of Physicians and Surgeons of Canada, and a member of the Defence Research Board. He is presently a member of the board of governors of York University.

WATCH FOR AN M.M.A. IMPORTANT ANNOUNCEMENT IN THE AUGUST-SEPTEMBER ISSUE

Detailmen's Directory

Representing Review Advertisers in this issue, whose names are not listed under a business address.

Arlington-Funk Laboratories, division U.S. Vitamin Corp. of Canada, Ltd.
Ed Lessor ..... HU 9-1841

British Drug Houses
W. S. Langdon ..... GL 3-1325
H. Harvey ..... TU 8-5341
D. W. (Don) Young ..... VE 2-0256

Ciba Company Ltd.
Leslie D. MacLean ..... CE 3-3240
Richard Loewen ..... ED 9-3135

Connaught Laboratories
Brathwaites Ltd. ..... WH 2-2635

Cow & Gate (Canada) Ltd.
R. O. (Bob) Patteson ..... VE 2-3660
Keith Searle ..... ED 9-1347

Frosst, Charles E.
W. M. Lougheed ..... HU 9-3963
W. J. McGurran ..... AL 3-0722
E. R. Mitchell ..... HU 9-6164
R. P. Roberts ..... AL 3-4032

Geigy Pharmaceuticals
L. H. Lockshin ..... ED 9-2175
T. (Tony) Ulicki ..... ED 4-4013

Horner, Frank W. Limited
Jos. Lavitt ..... ED 9-2180
Wes. Reimer ..... ED 9-3851
James N. Best ..... GL 3-6820

Lederle Laboratories
W. C. Hall ..... HU 9-2207
Ted Smith ..... AL 3-0437
R. D. Pollard ..... SP 2-4723
Bob Duff ..... JU 6-3628

McNeil Laboratories of Canada Ltd.
B. M. Coutts ..... JU 2-5920

Merck, Sharp and Dohme (Canada) Ltd.
W. G. Ball ..... GR 5-5702
Noel J. Pritchard ..... GL 2-6880
E. J. Strimbicki ..... AL 3-5767

Ortho Pharmaceutical Corp.
Don MacDonald ..... AL 3-4261

Poulenc Limited
J. B. Peters ..... VE 2-3862

Schmid (Canada) Ltd., Julius
H. V. Walker ..... LE 3-8664

Searle & Co., G. D.
Harry Chambers ..... ED 4-0989
B. Bishop ..... ED 8-8824

Smith & Nephew Ltd.
A. M. Middleton ..... JU 2-7946

Warner-Chilcott Labs.
A. L. (Andy) Argue ..... TU 8-1619
Gordon Harrower ..... AL 3-4147

Winthrop Laboratories
R. M. Kelly ..... Res. GR 5-6038
A. E. Pauwels ..... CE 3-2024

Wyeth & Brother, John
A. W. Cumming ..... HU 9-5694
Stuart Holmes ..... JU 9-4273